Hospital Admission Provision (Benefits After Contract Termination)

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Approved By:	Highmark Health Options – Market Leadership
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Products:	Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1 of 2

Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

Highmark Health Options may provide coverage under medical surgical benefits of the Company's Medicaid products for medically necessary

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus members.

POLICY POSITION

The hospital admission provision specifies financial payment responsibility of covered services when a subscriber is an inpatient of a hospital, skilled nursing facility (SNF), or rehabilitation facility on the day that coverage terminates.

Benefits should not be provided for services incurred prior to the subscriber's contract effective date, or during an inpatient admission that commenced prior to the contract effective date.

However, if the subscriber is an inpatient of a hospital, skilled nursing facility (SNF), or rehabilitation facility on the day that coverage terminates, benefits may be provided until the maximum amount of benefits has been paid, or until the inpatient stay ends, whichever occurs first.

The above provision does not apply to services rendered in a second facility if the patient is transferred from one type of facility to another (e.g., hospital to SNF, etc.). However, payment should be considered for services provided in a second facility when the patient is transferred from hospital to hospital when the first hospital is unable to treat the patient's condition(s). In this circumstance, admission to the second hospital is considered a continuation of the first admission. Transfers made at the patient's request for personal convenience are not covered under the hospital admission provision.

Coverage for hospital admission provisions is determined according to individual or group customer benefits.

References

Clinical Policy Management Committee – January 21, 2021.

POLICY UPDATE HISTORY

09/28/2022	Approved in Medical Policy Committee
10/2022	Approved in QI/UM