Payment Policy: Not Medically Necessary Inpatient Professional Service

Reference Number: CC.PP.060 Coding Implications
Date of Last Revision: 07/2026 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

Medical professional services performed in an inpatient facility location are only payable if the admission is determined to be medically necessary.

The purpose of this policy is to define payment criteria for medical professional services when the inpatient facility admission is denied as not medically necessary.

Application

Inpatient professional services
Inpatient Facility Claims
Participating and non-participating providers

Policy Description

All acute inpatient facility admissions require authorization. The health plan uses written clinical support criteria to evaluate medical necessity, level of care, and/or clinical appropriateness. When the inpatient facility admission is denied as not medically necessary, the associated professional services are also not payable. The health plan will not reimburse services which are not considered medically necessary.

Reimbursement

The health plan will utilize programmed claims logic to review inpatient professional claims and compare them to inpatient facility authorizations to draw a conclusion as to whether or not the professional services are payable.

In the event there is no matching inpatient authorization for the same member with dates of service included within the authorization date span, the professional claim will be denied with the following explanation code:

Explanation Code	Description
EXmg	NO AUTHORIZATION ON FILE FOR ASSOCIATED INPATIENT ADMISSION

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2025, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not

guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Definitions

EXmg – No authorization on file for associated inpatient admission

Inpatient Facility – For the purposes of this policy, a facility is defined as a Hospital, Skilled Nursing and other location and requires at least one overnight stay.

Inpatient Professional Services – Physician services rendered while a member has been admitted to an inpatient facility.

Member – A person insured or otherwise provided coverage.

Revision History	
06/01/2018	Initial Policy Draft
09/14/2018	Revised to Remove product types except for Medicaid; added "Inpatient Facility Claims" under Application section.
12/01/2019	Conducted review, updated
12/01/2020	Conducted review, updated important reminders and copyrights dates
12/01/2021	Conducted annual review. Removed "Product Type". Updated copyright dates.
12/01/2022	Conducted annual review, updated policy dates.
12/14/2023	Conducted annual review, updated policy dates
01/24/2025	Conducted annual review, updated policy dates.
12/02/2025	Conducted annual review, updated policy dates.
07/01/2026	Conducted annual review, updated policy dates.

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.

©2025 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.