If a conflict arises between a Clinical Payment and Coding Policy (CPCP) and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. BCBSTX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSTX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), ICD-10 CM and PCS, National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Outpatient Services Prior to an Inpatient Admission

Policy Number: CPCP038

Version 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: February 9, 2024

Plan Effective Date: February 22, 2024

Description

The purpose of this policy is to provide reimbursement information for services that are rendered to a member on the date of admission and up to the three (3) calendar days preceding the date of the admission, or otherwise noted in the provider contract. Services may include, but are not limited to, Emergency Department (ED), Observation and Pre-Admission Testing (PAT). This policy is not intended to address every reimbursement situation that may arise for outpatient services prior to an inpatient admission.

The purpose of the PAT is to ensure members do not have surgical contra-indications and the member's physiological baseline is obtained prior to the performance of the procedure. PAT is completed prior to any scheduled procedures, including surgery or scheduled admissions. This testing may include, but is not limited to, blood or tissue analysis, radiological testing, cardiac diagnostics, and respiratory status testing.

This policy applies to all hospitals and facilities within the same health system. The Plan will review claims that fall under the three-day payment window. **Additionally, providers should review their contract and other plan documents regarding preoperative/preadmission testing for scheduled admissions/surgeries to determine their contractual obligations.**

The Plan applies a three-day rule for services that are provided to outpatients who later are admitted as inpatients. Under the three-day payment window:

- If an admitting hospital renders **related diagnostic or related non-diagnostic services** three days preceding and including the date of a member's inpatient admission, the services are considered inpatient services and are included in the inpatient reimbursement; or
- If an admitting hospital renders **unrelated diagnostic or unrelated non-diagnostic outpatient services** three days preceding, including the date of a member's inpatient admission, the hospital may be reimbursed separately for the unrelated outpatient services.

Services provided during a member's admission to a facility for inpatient and outpatient services that are reimbursed under an all-inclusive payment method should be billed by the facility, and not by a third party. Services billed and provided by a third party while the member is admitted to said facility are the responsibility of that facility and should be included on the inpatient claim.

The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Claims may be reviewed on a case-by-case basis.

Definitions:

Diagnostic Services- Diagnostic services include any examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient service, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as, but not limited to, hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, and other tests given to determine the nature and severity of an ailment or injury.

Non-diagnostic Services: Service not identified by a diagnostic service revenue code or CPT code, e.g., therapeutic services. (AMA, CPT Manual).

Reimbursement Information:

The plan reviews claims for the three-day payment window that immediately precede the time of admission and any additional hours that fall during that calendar day. Facilities and providers are responsible for submitting appropriate codes and/or modifiers for services rendered.

The technical portion of all nondiagnostic services, other than the excluded services, provided by the hospital or facility within the same health system, **within the 3 days preceding or on the date of a member's inpatient admission** are considered related to the admission and must be included on the bill for the inpatient stay, unless the nondiagnostic services prior to admission are unrelated and clinically distinct from the reason for the member's inpatient hospital admission.

If the preadmission nondiagnostic services are unrelated and clinically distinct from the reason for the member's inpatient admission, the hospital or facility (including provider's practice or clinic) should include the technical portion of the services in their billing. The unrelated nondiagnostic services performed prior to the inpatient admission are not subject to the three-day payment window.

Condition Code 51

If the non-diagnostic outpatient services are not related to the inpatient admission, the hospital must report condition code 51 on the outpatient claim. Documentation must support that the outpatient non-diagnostic services are unrelated to the inpatient admission.

Modifier PD

Append modifier PD to physician preadmission diagnostic and admission-related nondiagnostic services, reported with HCPCS and/or CPT codes that are subject to the three-day payment window. Hospitals, facilities, physician's practices, and clinics within the same health system should notify each other of a member's inpatient admission prior to the inpatient stay that fall within the three-day payment window. If the modifier is appended, eligible claims will be reimbursed per the following:

- Only the Professional Component (PC) for CPT and/or HCPCS codes with a Technical Component (TC)/PC split that are provided in the three-day payment window, and
- The facility rate for codes without a TC/PC split.

Exclusions

The following are excluded from the policy when performed within the designated period prior to an inpatient admission:

- Ambulance services
- Chemotherapy and/or cancer related services

    - These services should not be included on the inpatient claim if they are not delivered on the same day of the inpatient admission. When these services are delivered on the same day as the inpatient admission, they must be included on the inpatient claim.
- Home Health Agency (HHA)
- Hospice
- Outpatient maintenance renal dialysis services
- Rural Health Clinic (RHC)
- Skilled Nursing Facility (SNF)

- Therapies
    - Cardiac
    - Occupational Therapy (OT)
    - Physical Therapy (PT)
    - Speech Therapy (PT)
    - Respiratory Therapy
- Transplants

The following hospitals and/or, hospital units that fall within a one (1) day payment window preceding an inpatient admission are excluded from this policy, such as:

- Cancer hospitals
- Children's hospitals
- Inpatient rehabilitation hospitals and units
- Long-term care hospitals
- Psychiatric/Substance Abuse hospitals and units

Additional Resources:

Clinical Payment and Coding Policies

CPCP001 Observation Services Policy

CPCP002 Inpatient/Outpatient Unbundling Policy-Facility

CPCP014 Global Surgical Package-Professional Providers

CPCP023 Modifier Reference Policy

CPCP030 Point-of-Care Ultrasound Examination Policy

CPCP039 Outpatient Service(s) Overlapping During an Inpatient Stay

References:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2373CP.pdf

CMS MLN Matters, FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients. Accessed December 1, 2022. https://www.cms.gov/files/document/se20024.pdf

CMS Medicare Benefit Policy Manual, Chapter 6- Hospital Services Covered Under Part B. Section 20.4.1-Diagnostic Services Defined. Accessed December 1, 2022. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf

CMS Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1. Accessed December 1, 2022. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2373CP.pdf

Policy Update History:

2/28/2023	New policy
2/9/2024	Annual Review