BlueCross BlueShield Minnesota

COMMERCIAL REIMBURSEMENT POLICY

Outpatient Hospital Services Prior to an Inpatient Admission

Active

Policy Number:	Facility - 006
Policy Title:	Outpatient Hospital Services Prior to an Inpatient Admission
Section:	Facility
Effective Date:	11/01/23

Description

This policy addresses the coding and reimbursement of outpatient hospital services rendered prior to an inpatient admission. Such services include, but are not limited to, emergency department, observation and pre-admission testing.

Definitions

Diagnostic service: “A service is “diagnostic” if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, 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 hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury.”

Pre-admission testing: Testing to determine whether or not the patient needs to be admitted as an inpatient or to ensure surgical patients have no contra-indications and the patient’s physiological baseline is obtained prior to the performance of the procedure. Testing may include blood or tissue analysis, radiological testing, cardiac diagnostics, respiratory status testing, etc.

Related services: Services provided in connection with the principal diagnosis assigned to the inpatient claim.

Policy Statement

If an admitting hospital furnishes diagnostic services three days prior to and including the date of a patient’s inpatient admission, the services are considered inpatient services and are included in the inpatient payment.

If a hospital renders non-diagnostic outpatient services up to three days prior to, including the date of a patient’s inpatient admission, and the non-diagnostic outpatient services are unrelated to the inpatient admission, the hospital can separately bill for the outpatient non-diagnostic services.

If the non-diagnostic outpatient services are related to the inpatient principal diagnosis code, the services are considered inpatient services and are not to be billed on an outpatient claim (services must be billed on an inpatient claim).

Note: For psychiatric and inpatient rehabilitation facilities, this policy applies only to the day of and one day prior to inpatient admission.

This policy does not apply to:

- Ambulance services
- Critical access hospitals
- Chemotherapy and/or cancer related services
- Maintenance renal dialysis services
- Maternity services
- Inpatient or residential substance use disorder facilities
- Services provided by other facilities

In the following scenarios, the outpatient services must be billed on the inpatient claim:

- **Emergency department (ED) services:** a patient receives ED services within the 3 days prior to an inpatient admission to the same facility for a related diagnosis.
- **Observation services:** a patient receives observation services within the 3 days prior to an inpatient admission to the same facility for a related diagnosis.
- **Pre-admission testing or other outpatient services:** a patient receives pre-admission testing or other outpatient services within the 3 days prior to an inpatient admission to the same facility for a related diagnosis.

Pre-admission services are subject to retrospective post-payment audits and possible recoupments in accordance with this and other policies as applicable.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier: N/A
ICD-10 Diagnosis: N/A
ICD-10 Procedure: N/A
CPT/HCPCS: N/A
Revenue Codes: N/A

Resources

Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1

Policy History

03/23/2021	Initial Committee Approval
01/25/2022	Revised
10/24/2023	Revised