



Reimbursement Policy

Subject: Preadmission Services for Inpatient Stays

Effective Date: **04/01/16**

Committee Approval Obtained: **02/11/16**

Section: **Facilities**

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to <https://providers.amerigroup.com/ia>. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement by Amerigroup Iowa, Inc. if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim
- Recover and/or recoup claim payment

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy

Amerigroup allows reimbursement for applicable services for a covered member prior to admission to an inpatient hospital (referred to as the payment window) unless provider, state, federal or CMS contracts and/or requirements indicate otherwise, based on CMS guidance as follows:

- For admitting hospitals, preadmission services are included in the inpatient reimbursement for the three (3) days prior to and

including the day of the member's admission, and therefore are not separately reimbursable expenses

NOTE: This includes any entity wholly owned or wholly operated by the admitting hospital or by another entity under arrangements with the admitting hospital.

- For other hospitals and units, preadmission services are included in the inpatient reimbursement within one (1) day prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses, including:
 - Psychiatric hospitals and units
 - Inpatient rehabilitation facilities and units
 - Long-term care hospitals
 - Children's hospitals
 - Cancer hospitals
- For Critical Access Hospitals (CAH), preadmission services are not subject to either the three (3) day or one (1) day payment window and, therefore, are separately reimbursable expenses from the inpatient stay reimbursement.
- The three (3) day or one (1) day payment window does not apply to preadmission services included in the Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) all-inclusive rate.

Preadmission Services

Preadmission services are included in the inpatient reimbursement and consist of all diagnostic outpatient services and admission-related outpatient nondiagnostic services.

A hospital may attest to specific nondiagnostic services as being unrelated by adding a condition code 51 to the outpatient nondiagnostic service to be billed separately.

Nonreimbursable

Amerigroup does not consider the following services to be included in the payment window prior to an inpatient stay for preadmission services:

- Ambulance services
- Maintenance renal dialysis services
- Services provided by:

	<ul style="list-style-type: none"> - Skilled nursing facilities - Home health agencies - Hospices • Unrelated nondiagnostic services <p>NOTE: These services may be considered for separate outpatient reimbursement.</p>
History	<ul style="list-style-type: none"> • Initial Amerigroup review approved 02/11/16 and effective 04/01/16
References and Research Materials	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • CMS • State Medicaid • State contracts • U.S. Department of Health and Human Services, Office of the Inspector General Final Report, Expansion of the Diagnosis Related Group Payment Window, A-01-02-00503, August 2003
Definitions	<ul style="list-style-type: none"> ▪ Admission-Related Outpatient Nondiagnostic Services: Services that are furnished in connection with the principal diagnosis assigned to the inpatient admission (CMS, <i>Implementation of New Statutory Provision Pertaining to Medicare 3-Day Payment Window – Outpatient Services Treated as Inpatient</i>, August 2010) ▪ Condition Code 51: Denotes attestation of Unrelated Outpatient Non-Diagnostic Services • General Reimbursement Policy Definitions
Related Policies	<ul style="list-style-type: none"> • Modifier Usage • Transportation Services: Ambulance and Non-Emergent Transport
Related Materials	<ul style="list-style-type: none"> • None