PREADMISSION AND PREOPERATIVE SERVICES

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Description

Preadmission and preoperative services are often necessary to ensure the health and safety of a member before they undergo surgery or an inpatient admission. A wide range of examinations and diagnostics may be considered preadmission or preoperative services, including, but not limited to X-ray, laboratory tests, and EKGs.

Centers for Medicare and Medicaid Services (CMS) “Three-day window” rule considers these related preadmission and preoperative services incidental to the subsequent facilities admission or surgical payment.

CMS “Three-day window” definition:
“Defined as three (3) days prior to and including the date the beneficiary is admitted as an inpatient. For example, if a beneficiary is admitted as an inpatient on Wednesday, then Sunday, Monday, Tuesday, or Wednesday is part of the three-day window. Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services that are furnished to the beneficiary during the 3-day payment window.” (Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1)

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment. (Medicare Claims Processing Manual, Pub. 100-04, Chapter 3, Section 40.3)

This policy applies to facility claims. Please refer to global allowance rules in the Global Surgery and Bundling Guidelines policy for professional claims.

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will reimburse preadmission and preoperative services according to the criteria outlined in this policy.

Reimbursement Guidelines

The following scenarios will be denied when billed:

- Preadmission diagnostic services in an outpatient hospital when billed within three days immediately prior to an inpatient admission by the same Tax ID and Provider ID.

- Services, other than ambulance, provided by an outpatient hospital when billed for the same date of service as the inpatient admission by the same Tax ID and Provider ID.

- Nondiagnostic services, other than ambulance, provided by an outpatient hospital when billed within the three days prior to an inpatient admission by the same Tax ID and Provider ID, when condition code 51 is not present on the claim.

Rationale

Based on CMS guidance, preadmission and preoperative services performed by the admitting hospital within three (3) days of inpatient admission, including the date of admission, are deemed to be included in the subsequent inpatient admission payment.

Additionally, we encourage you to review your facility's Blue Cross NC contract regarding preoperative/preadmission testing for scheduled admissions/surgeries to determine your contractual obligations.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com.

*CMS defines the following revenue codes as diagnostic service codes:

Revenue Code	Description
0254	Pharmacy drugs incident to other diagnostic services
0255	Pharmacy drugs incident to radiology
0300-0309	Laboratory
0310-0319	Laboratory pathological
0320-0329	Radiology-diagnostic
0341	Nuclear medicine-diagnostic
0343	Nuclear medicine-diagnostic radiopharmaceuticals
0350-0359	CT scan
0371	Anesthesia incident to radiology
0372	Anesthesia incident to other diagnostic services
0400-0409	Other imaging services

0460-0469	Pulmonary function
0471	Audiology-diagnostic
0481, 0489	Cardiology, cardiac catheter lab and other with CPT®/HCPCS codes 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571, 93572, G0275, and G0278
0482, 0483	Cardiology-diagnostic
0530-0539	Osteopathic services
0610-0619	Magnetic resonance technology (MRT)
0620-0629	Medical/surgical supplies
0730-0739	EKG/ECG
0740-0749	EEG
0918	Psychiatric/psychological services testing
0920-0929	Other diagnostic services

Related policy

Bundling Guidelines

Global Surgery

References

Healthcare Common Procedure Coding System

American Medical Association, *Current Procedural Terminology* (CPT®)

Centers for Disease Control and Prevention, International Classification of Diseases, 10th Revision

CMS Medicare Claims Processing Manual

The Blue Book/ Provider E manual

History

6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)

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Medicare Reimbursement Policy

12/31/2022	Routine Policy Review. Minor revisions only. (cjw)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing, and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.