Inpatient Acute Medical Admission
Payment Policy

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted acute care hospitals for covered, medically necessary inpatient acute medical admission services for our commercial members.

Inpatient acute medical admissions include services and items furnished to an inpatient, including room and board, nursing care and related services, diagnostic and therapeutic services, and medical and surgical services.

General Benefit Information

Services and subsequent payment are based on the member’s benefit plan and provider Agreement. Providers and their office staff may use our electronic technologies to verify effective dates and member copayments before initiating services. Please visit our eTools page to access links that provide information on member eligibility and benefits. Member liability may include, but is not limited to, copayments, deductibles, and co-insurance, and will be applied depending upon the member’s benefit plan.

Certain services may require prior authorization or referral. Please refer to the member’s subscriber certificate for more information and Authorization Requirements by Product.

Payment Information

Blue Cross reimburses health care providers based on:

- Network provider reimbursement or contracted rates and
- Member benefits

Claims are subject to payment edits, which Blue Cross updates regularly.

**Blue Cross reimburses:**

- Inpatient acute medical admissions at a single all-inclusive APR-DRG rate or as otherwise determined by the provider contract for inpatient services.
  - Reimbursement includes, but is not limited to:
    - Ancillary services
    - Anesthesia care
    - Appliances and equipment
    - Diagnostic services
    - Medication and supplies
    - Nursing care
    - Radiology
    - Recovery room services
    - Semi-private room (or private room, if necessary)
    - Surgical procedures
    - Therapeutic items (drugs and biologicals)
    - Any diagnostic services rendered by the same facility within three days of an inpatient admission.
    - Any related outpatient service rendered by the same facility within three days of an inpatient admission, including surgery, emergency care, radiology or laboratory procedures
    - Observation services rendered by the same facility within 48 hours of an inpatient admission
    - Any outpatient service rendered by the admitting hospital that directly results in the inpatient stay.

- Inpatient acute medical admissions as readmissions when a member is discharged and then readmitted to the same hospital within seven days subsequent to the prior admission’s discharge date for the same or related diagnosis.
  - In such cases, Blue Cross establishes the first original day of admission as the date of admission for the consolidated claim.

- Mental health and substance abuse admissions at a per diem rate and capped at the standard rate for the DRG.

- Short inpatient stays at a per diem rate and capped at the standard rate for the DRG. Short stays are admissions lasting less than 20 percent of the average length of stay per DRG and severity.

- Transfers to another acute care hospital (including children’s hospitals, psychiatric units of an acute care hospital, or designated cancer care hospitals):
Transferring acute care hospital is reimbursed at a per diem rate and capped at the standard rate for the DRG. Receiving acute care hospital is reimbursed for the transferred case as a new inpatient stay. Transfers within an acute care hospital from the medical surgical unit to a psychiatric unit are treated like new admissions to another facility.

Blue Cross does not reimburse:
- Custodial care
- Personal care items
- Purchased services, which are services that are performed by another provider during the member’s inpatient stay, either onsite at the admitting hospital or offsite, such as a mobile imaging provider
- Services rendered after discharge as part of the inpatient admission
- Services considered to be general routine services separately from the standard “room and board” charge. These services include regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

General reimbursement information:
- Coverage for an inpatient stay is determined by the admission date. If a member acquires coverage after admission, the inpatient stay is not covered. However, if a member loses coverage during the stay, the inpatient facility services are reimbursable.
- Reimbursement for admissions using the APR-DRG methodology is based on the contracted rate applicable to the member’s health plan for the rate period.
  - The inpatient discharge date determines the rate period.
  - Reimbursement is determined by discharge date so that all services rendered through discharge are included in the DRG and severity determination.
- Reimbursement for admissions using a methodology other than APR-DRG is based on the contracted rate applicable to the member’s health plan for the rate period, which is determined by the admission date.
- Reimbursement for admissions that qualify as readmission are subject to post-payment audits and retraction. Diagnoses and procedures from both claims are then combined and regrouped to derive a new consolidated DRG and severity. The claim for the second admission will be rejected as a duplicate, and the initial claim is adjusted.
- Reimbursement for outpatient services preceding the admission, that are considered included in the inpatient payment, are subject to post-payment audits and retraction.
- Blue Cross uses Medicare’s definition for diagnostic services, which describes them as services that facilitate the assessment of a medical condition or identification of a disease. Please refer to Medicare Benefit Policy Manual, Chapter 6, Section 20 and Medicare Claims Processing Manual, Chapter 3, Section 40.3

Billing Information

Transfers from one acute care facility to another acute care facility
- Facility A – Use the appropriate member discharge status code to identify the type of facility to which the member is being transferred. See the discharge status codes on the table below.
- Facility B – Treat the member transferring in as a new admission. Authorization is required and may be obtained by:
  - Submitting authorization notifications electronically via Emdeon/Change Health Office available through Provider Central, the POS device, or
  - Calling Health Management Programs and Operations at 1-800-327-6716.

Transfers within the same acute care facility
- Treat the transfer as a new admission. Authorization requirements apply.
- Enter the appropriate billing center number and/or NPI on each claim.
- **Transfer from medical/surgical to psychiatric unit:** Use member discharge status code 02 or 05 (transfer) on the medical/surgical claim
- **Transfer from medical/surgical to rehabilitation or rehabilitation to medical/surgical:** Use member discharge status code 62 (discharge) on the first claim
- **Transfer from psychiatric to medical/surgical:** Use member discharge status code 02 (discharge) on the psychiatric claim
Outpatient and observation services preceding the inpatient admission

- Hospitals reimbursed under the APR-DRG methodology should
  - Bill all charges for outpatient services except observation, provided within three days prior to the admission as part of the inpatient claim.
  - Bill charges for observation services provided 48 hours prior to the admission as part of the inpatient claim.
- Hospitals not reimbursed under the APR-DRG methodology should submit outpatient charges on a separate outpatient claim, using occurrence code 40 to enter the date of the scheduled admission.

Newborn babies

- Birth weight must be reported in grams on all newborn claims for accurate DRG processing.
- See the Newborn and Neonatal Intensive Care Services policy for additional billing instructions.

Present on admission

- The present on admission (POA) indicator must be reported on all inpatient claims for accurate DRG processing.
- See the Serious Reportable Events payment policy for additional information.

<table>
<thead>
<tr>
<th>Description</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td><strong>Discharge status codes</strong></td>
<td></td>
</tr>
<tr>
<td>01</td>
<td>Discharged to home or self-care (routine discharge)</td>
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<tr>
<td>02</td>
<td>Discharged or transferred to another short-term general hospital for inpatient care</td>
</tr>
<tr>
<td>05</td>
<td>Discharged or transferred to a designated cancer center or children’s hospital</td>
</tr>
<tr>
<td>62</td>
<td>Discharged or transferred to an inpatient rehabilitation facility including rehabilitation distinct part units of a hospital</td>
</tr>
<tr>
<td>65</td>
<td>Discharged or transferred to a psychiatric hospital</td>
</tr>
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| **Occurrence codes** | |
| 40 | Scheduled date of admission | Valid only on the outpatient claim. Must be used with occurrence code 41 |
| | On UB04 FL31-34 | Non-DRG hospitals should designate the approved date admission date on the outpatient claim for preadmission services |
| | On 837I Loop 2300 | Designate occurrence code 40 in H101-2 and the approved admission date in HI01-4 on the outpatient claim for preadmission testing |
| 41 | Date of first test for preadmission testing | On UB04 FL31-34 Non-DRG hospitals should designate the preadmission test date on the outpatient claim. |
| | On 837I 2300 HI loop | Designate occurrence code 41 in H101-2 and the preadmission test date in HI01-4 on the outpatient claim for preadmission testing |

<p>| <strong>Value codes</strong> | |
| 30 | Preadmission testing | On UB04 Designate 30 in the value code field and record the charges for preadmission testing |
| | On 837I 2300 HI loop | Designate the value code 30 in HI01-2. Record the charges for preadmission testing in HI01-5 |</p>
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| 54 Newborn birth weight in grams | On UB04  
- Designate 54 in the value code field and record the birth weight in grams in the corresponding amount field.  

On 837I  
- Designate the value code 54 in HI01-2 position of the 2300 HI loop.  
- Record the birth weight in HI01-5 position of the 2300 HI loop. |

**Present on admission (POA) codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>UB04</th>
<th>837I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at time of inpatient admission.</td>
<td>- Report in FL 67</td>
<td></td>
</tr>
</tbody>
</table>
- Loop 2300, report in HI01-9 (corresponds to the diagnosis reported in HI01-2) |
| N    | Diagnosis was not present at time of inpatient admission. |  
- Do not submit a blank on an electronic claim.  
- Report “1” instead. |
| U    | Documentation insufficient to determine if the condition was present at the time of inpatient admission |  
- Do not submit a blank on an electronic claim.  
- Report “1” instead. |
| W    | Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission |  
- Do not submit a blank on an electronic claim.  
- Report “1” instead. |
| 1 or blank | Unreported or not used. Exempt from POA reporting. This code is equivalent to a blank on the UB-04, however, it was determined that blanks are undesirable when submitting this data via the 4010A. |  
- Do not submit a blank on an electronic claim.  
- Report “1” instead. |

When submitting claims for reimbursement, report all services with:
- Up-to-date industry-standard procedure and diagnosis codes
- Modifiers that affect payment in the first modifier field, followed by informational modifiers

### Related Policies

- General coding and billing
- Observation services
- Newborn and neonatal intensive care services
- Serious reportable events

### Policy Update History

- **10/03/2014** Documentation of existing policy
- **12/08/2015** Template update; annual review; inclusion of information on ancillary services provided to the patient; inclusion of information on purchased services for DRG hospitals; inclusion of information on daily notification reports; inclusion of information on inter-facility transfers for DRG hospitals; inclusion of information on billing guidelines for inter-facility transfer, intra-facility transfer, observation and inpatient claims, and pre-admission testing
- **04/10/2018** Template update; annual review; clarified existing practices on preadmission rules, billing requirements for newborns and POA, clarification on readmission, definition of diagnostic services

*This document is for informational purposes only and is not an authorization, an explanation of benefits, or a contract. Receipt of benefits is subject to satisfaction of all terms and conditions of the coverage. Medical technology is constantly changing, and we reserve the right to review and update our policies periodically.*

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Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts’ payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy
development takes into consideration a variety of factors, including: the terms of the participating provider’s contract(s); scope of benefits included in a given member’s benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.