Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-039		
Subject:	Outpatient Services Prior To An Inpatient Admission		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	August 1, 2025	**Revised Date:**	August 2025
Date Reviewed:	April 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan.

REIMBURSEMENT GUIDELINES:

This policy provides direction on the Plan's reimbursement related to outpatient services rendered prior to an inpatient admission. Such services include, but are not limited to, Emergency Department (ED), Observation (OBS) and Pre-Admission Testing (PAT).

The purpose of Pre-Admission Testing (PAT) is to ensure patients have no surgical contra-indications and the patient's physiological baseline is obtained prior to the performance of the procedure. PAT is done prior to scheduled procedures, including surgery or scheduled admissions. Testing may include blood or tissue analysis, radiological testing, cardiac diagnostics, respiratory status testing, etc.

The Plan applies a three (3) day rule, also known as the 72-hour rule, for services provided to outpatients who later are admitted as inpatients.

According to the three (3) day or 72-hour rule:

- If an admitting hospital or an entity affiliated within the same system furnishes **diagnostic services** three days prior to and including the date of a Member's inpatient admission, the services are considered inpatient services and are included in the inpatient payment (e.g. bundled service). For purposes of this Policy "same system" is defined as any entity or entities that directly control, is controlled by, or is under common control with the admitting hospital including but not limited to hospitals and freestanding facilities wholly owned or wholly operated by a health system parent or parents (e.g., outpatient department of a hospital in the same system, affiliated freestanding diagnostic testing center in the same system, affiliated ambulatory surgery center, etc. or an entity

under arrangement with a hospital in the same system); **or**,

- If a hospital or an entity affiliated within the same system renders **non-diagnostic outpatient services** three days prior to, including the date of a beneficiary's inpatient admission, and the non-diagnostic outpatient services are **unrelated** to the inpatient admission, the hospital is permitted to separately bill for the non-diagnostic outpatient services (e.g. unbundled).

Note: If the **non-diagnostic outpatient services** are **related** to the inpatient admission, the services are considered inpatient services and are not separately reimbursable.

Facility Services (UB-04 Claim Form)

The Plan applies the guidelines below when outpatient services are performed at the **same** facility or an entity affiliated within the same system for a **related** diagnosis. These guidelines are applicable whether the Member remains at the facility throughout the time period or leaves the facility and returns to be admitted within the time period.

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

The table below indicates the guidelines when outpatient services must be billed on the inpatient claim:

Scenario	If…	Then…
Member receiving Emergency Department (ED) services	a member receives ED services within a **3-day** period prior to an inpatient admission to the **same** facility or an entity affiliated within the same system for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.
Member receiving Observation services	a member receives Observation services within a **3-day** period prior to an inpatient admission to the **same** facility or an entity affiliated within the same system for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.
Member receiving Pre-Admission Testing or other Outpatient services	a member receives Pre-Admission Testing or other Outpatient services within a **3-day** period prior to an inpatient admission to the **same** facility or an entity affiliated within the same system for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.

Excluded Services (Commercial Products Only)

Certain outpatient services are excluded from this policy when performed within the designated period prior to an inpatient admission. These services are not to be included on the inpatient claim and must be independently billed. Applicable services are as follows:

Chemotherapy and/or Outpatient Surgery

These services should not be included on the inpatient claim as long as they are ***not performed on the same day*** of the inpatient admission. If they are performed on the same day as the inpatient admission, then they must be included on the inpatient claim.

Maternity Services

Outpatient diagnostic and/or Emergency Department services provided ***in conjunction with a maternity-related diagnosis*** prior to the inpatient admission should not be included on the inpatient claim.

Professional Services (1500 Claim Form)

Inpatient Preoperative Care

Preoperative care furnished by a provider three (3) days prior to an inpatient admission is considered included in the reimbursement for the inpatient services submitted by the admitting hospital (e.g. bundled service).

However, reimbursement may be permitted for unusual preoperative medical care or for medical treatment attempted to avoid an operation, even though surgery eventually was necessary. The Plan reserves the right to determine what medical care is acceptable to be reimbursed in these situations.

DEFINITIONS:

Three-day window

Defined as three (3) days prior to and including the date the Member is admitted as an inpatient. For example, if a Member is admitted as an inpatient on Wednesday, then Sunday, Monday, Tuesday, or Wednesday is part of the three-day window.

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."

Non-diagnostic outpatient service

A service not identified by a diagnostic service revenue code or CPT code. (American Medical Association, Current Procedural Terminology Manual)

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-035: Correct Coding Guidelines

REFERENCES:

- Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1
- Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1
- American Medical Association, Current Procedural Terminology Manual

POLICY UPDATE HISTORY INFORMATION:

11 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
2 / 2024	Administrative policy review with no changes in policy direction
7 / 2025	Added direction on same system applicable to West Virginia, Delaware, Pennsylvania
8 / 2025	Direction on same system applicable to New York

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-039		
Subject:	Outpatient Services Prior To An Inpatient Admission		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	February 5, 2024	**Revised Date:**	February 2024
Date Reviewed:	January 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy provides direction on The Plan's reimbursement related to outpatient services rendered prior to an inpatient admission. Such services include, but are not limited to, Emergency Department (ED), Observation (OBS) and Pre-Admission Testing (PAT).

The purpose of Pre-Admission Testing (PAT) is to ensure patients have no surgical contra-indications and the patient's physiological baseline is obtained prior to the performance of the procedure. PAT is done prior to scheduled procedures, including surgery or scheduled admissions. Testing may include blood or tissue analysis, radiological testing, cardiac diagnostics, respiratory status testing, etc.

BACKGROUND:

The Centers for Medicare & Medicaid Services (CMS) applies a three (3) day rule, also known as the 72-hour rule, for services provided to outpatients who later are admitted as inpatients. According to the three (3) day rule:

- If an admitting hospital (or an entity wholly-owned, wholly-operated, or under arrangement with the admitting hospital) furnishes **diagnostic services** three days prior to and including the date of a beneficiary's inpatient admission, the services are considered inpatient services and are included in the inpatient payment (e.g. bundled service); **or**,
- If a hospital renders **non-diagnostic outpatient services** three days prior to, including the date of a beneficiary's inpatient admission, and the non-diagnostic outpatient services are **unrelated** to the

inpatient admission, the hospital is permitted to separately bill for the non-diagnostic outpatient services (e.g. unbundled).

Note: If the **non-diagnostic outpatient services** are **related** to the inpatient admission, the services are considered inpatient services and are not separately reimbursable.

CMS DEFINITIONS:

Three-day window

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. (Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1)

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." (Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1)

Non-diagnostic outpatient service

A service not identified by a diagnostic service revenue code or CPT code. (American Medical Association, Current Procedural Terminology Manual)

REIMBURSEMENT GUIDELINES:

Section A - Applicable to Facility Services (UB-04 Claim Form)

The Plan's Commercial and Medicare Advantage products apply a policy similar to the Centers for Medicare & Medicaid Services (CMS) when outpatient services are performed at the **same** facility for a **related** diagnosis.

The guidelines shown below are applicable whether or not the member remains at the facility throughout the time period or leaves the facility and returns to be admitted within the time period.

Commercial and Medicare Advantage Products

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

The table below indicates the guidelines when outpatient services must be billed on the inpatient claim:

Scenario	If…	Then…
Member receiving Emergency Department (ED) services	a member receives ED services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.
Member receiving Observation services	a member receives Observation services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.
Member receiving Pre-Admission Testing or other Outpatient services	a member receives Pre-Admission Testing or other Outpatient services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.

Excluded Services (Commercial Products Only)

Certain outpatient services are excluded from this policy when performed within the designated period prior to an inpatient admission. These services are not to be included on the inpatient claim and must be independently billed. Applicable services are as follows:

Chemotherapy and/or Outpatient Surgery

These services should not be included on the inpatient claim as long as they are ***not performed on the same day*** of the inpatient admission. If they are performed on the same day as the inpatient admission, then they must be included on the inpatient claim.

Maternity Services

Outpatient diagnostic and/or Emergency Department services provided ***in conjunction with a maternity-related diagnosis*** prior to the inpatient admission should not be included on the inpatient claim.

Section B - Applicable to Professional Services (1500 Claim Form)

Inpatient Preoperative Care

Preoperative care furnished by a provider three (3) days prior to an inpatient admission is considered included in the reimbursement for the inpatient services submitted by the admitting hospital (e.g. bundled service).

However, reimbursement may be permitted for unusual preoperative medical care or for medical treatment attempted to avoid an operation, even though surgery eventually was necessary. The Plan reserves the right to determine what medical care is acceptable to be reimbursed in these situations.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Highmark Provider Manual (Chapter 6, Unit 3)

REFERENCES:

- Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1
- Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1
- American Medical Association, Current Procedural Terminology Manual

POLICY UPDATE HISTORY INFORMATION:

11 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy
2 / 2024	Administrative policy review with no changes in policy direction

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-039		
Subject:	Outpatient Services Prior To An Inpatient Admission		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	January 3, 2022	**Revised Date:**	January 2022
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy provides direction on The Plan's reimbursement related to outpatient services rendered prior to an inpatient admission. Such services include, but are not limited to, Emergency Department (ED), Observation (OBS) and Pre-Admission Testing (PAT).

The purpose of Pre-Admission Testing (PAT) is to ensure patients have no surgical contra-indications and the patient's physiological baseline is obtained prior to the performance of the procedure. PAT is done prior to scheduled procedures, including surgery or scheduled admissions. Testing may include blood or tissue analysis, radiological testing, cardiac diagnostics, respiratory status testing, etc.

BACKGROUND:

The Centers for Medicare & Medicaid Services applies a three (3) day rule, also known as the 72-hour rule, for services provided to outpatients who later are admitted as inpatients. According to the three (3) day rule:

- If an admitting hospital (or an entity wholly-owned, wholly-operated, or under arrangement with the admitting hospital) furnishes **diagnostic services** three days prior to and including the date of a beneficiary's inpatient admission, the services are considered inpatient services and are included in the inpatient payment (e.g. bundled service); **or**,
- If a hospital renders **non-diagnostic outpatient services** three days prior to, including the date of a beneficiary's inpatient admission, and the non-diagnostic outpatient services are **unrelated** to the inpatient admission, the hospital is permitted to separately bill for the non-diagnostic outpatient services (e.g. unbundled).

Note: If the **non-diagnostic outpatient services** are **related** to the inpatient admission, the services are considered inpatient services and are not separately reimbursable.

CMS DEFINITIONS:

Three-day window

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. (Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1)

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." (Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1)

Non-diagnostic outpatient service

A service not identified by a diagnostic service revenue code or CPT code. (American Medical Association, Current Procedural Terminology Manual)

REIMBURSEMENT GUIDELINES:

Section A - Applicable to Facility Services (UB-04 Claim Form)

The Plan's Commercial and Medicare Advantage products apply a policy similar to the Centers for Medicare & Medicaid Services (CMS) when outpatient services are performed at the **same** facility for a **related** diagnosis.

The guidelines shown below are applicable whether or not the member remains at the facility throughout the time period or leaves the facility and returns to be admitted within the time period.

Commercial and Medicare Advantage Products

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

The table below indicates the guidelines when outpatient services must be billed on the inpatient claim:

Scenario	If…	Then…
Member receiving Emergency Department (ED) services	a member receives ED services within a **3-day** period prior to an	**all** services shall be billed on the inpatient claim.

	inpatient admission to the **same** facility for a **related** diagnosis…	
Member receiving Observation services	a member receives Observation services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.
Member receiving Pre-Admission Testing or other Outpatient services	a member receives Pre-Admission Testing or other Outpatient services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.

Excluded Services (Commercial Products Only)

Certain outpatient services are excluded from this policy when performed within the designated period prior to an inpatient admission. These services are not to be included on the inpatient claim and must be independently billed. Applicable services are as follows:

Chemotherapy and/or Outpatient Surgery

These services should not be included on the inpatient claim as long as they are ***not performed on the same day*** of the inpatient admission. If they are performed on the same day as the inpatient admission, then they must be included on the inpatient claim.

Maternity Services

Outpatient diagnostic and/or Emergency Department services provided ***in conjunction with a maternity-related diagnosis*** prior to the inpatient admission should not be included on the inpatient claim.

Section B - Applicable to Professional Services (1500 Claim Form)

Inpatient Preoperative Care

Preoperative care furnished by a provider three (3) days prior to an inpatient admission is considered included in the reimbursement for the inpatient services submitted by the admitting hospital (e.g. bundled service).

However, reimbursement may be permitted for unusual preoperative medical care or for medical treatment attempted to avoid an operation, even though surgery eventually was necessary. The Plan reserves the right to determine what medical care is acceptable to be reimbursed in these situations.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Highmark Provider Manual (Chapter 6, Unit 3)

REFERENCES:

- Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1
- Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1
- American Medical Association, Current Procedural Terminology Manual

POLICY UPDATE HISTORY INFORMATION:

11 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy
1 / 2022	Added Delaware Medicare Advantage applicable to the policy

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-039		
Subject:	Outpatient Services Prior To An Inpatient Admission		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	November 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☐	**NY** ☒
Applicable Claim Type	**UB**	☒	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy provides direction on The Plan's reimbursement related to outpatient services rendered prior to an inpatient admission. Such services include, but are not limited to, Emergency Department (ED), Observation (OBS) and Pre-Admission Testing (PAT).

The purpose of Pre-Admission Testing (PAT) is to ensure patients have no surgical contra-indications and the patient's physiological baseline is obtained prior to the performance of the procedure. PAT is done prior to scheduled procedures, including surgery or scheduled admissions. Testing may include blood or tissue analysis, radiological testing, cardiac diagnostics, respiratory status testing, etc.

BACKGROUND:

The Centers for Medicare & Medicaid Services applies a three (3) day rule, also known as the 72-hour rule, for services provided to outpatients who later are admitted as inpatients. According to the three (3) day rule:

- If an admitting hospital (or an entity wholly-owned, wholly-operated, or under arrangement with the admitting hospital) furnishes **diagnostic services** three days prior to and including the date of a beneficiary's inpatient admission, the services are considered inpatient services and are included in the inpatient payment (e.g. bundled service); **or**,
- If a hospital renders **non-diagnostic outpatient services** three days prior to, including the date of a beneficiary's inpatient admission, and the non-diagnostic outpatient services are **unrelated** to the inpatient admission, the hospital is permitted to separately bill for the non-diagnostic outpatient services (e.g. unbundled).

Note: If the **non-diagnostic outpatient services** are **related** to the inpatient admission, the services are considered inpatient services and are not separately reimbursable.

CMS DEFINITIONS:

Three-day window

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. (Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1)

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." (Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1)

Non-diagnostic outpatient service

A service not identified by a diagnostic service revenue code or CPT code. (American Medical Association, Current Procedural Terminology Manual)

REIMBURSEMENT GUIDELINES:

Section A - Applicable to Facility Services (UB-04 Claim Form)

The Plan's Commercial and Medicare Advantage products apply a policy similar to the Centers for Medicare & Medicaid Services (CMS) when outpatient services are performed at the **same** facility for a **related** diagnosis.

The guidelines shown below are applicable whether or not the member remains at the facility throughout the time period or leaves the facility and returns to be admitted within the time period.

Commercial and Medicare Advantage Products

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

The table below indicates the guidelines when outpatient services must be billed on the inpatient claim:

Scenario	If…	Then…
Member receiving Emergency Department (ED) services	a member receives ED services within a **3-day** period prior to an	**all** services shall be billed on the inpatient claim.

	inpatient admission to the **same** facility for a **related** diagnosis…	
Member receiving Observation services	a member receives Observation services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.
Member receiving Pre-Admission Testing or other Outpatient services	a member receives Pre-Admission Testing or other Outpatient services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.

Excluded Services (Commercial Products Only)

Certain outpatient services are excluded from this policy when performed within the designated period prior to an inpatient admission. These services are not to be included on the inpatient claim and must be independently billed. Applicable services are as follows:

Chemotherapy and/or Outpatient Surgery

These services should not be included on the inpatient claim as long as they are ***not performed on the same day*** of the inpatient admission. If they are performed on the same day as the inpatient admission, then they must be included on the inpatient claim.

Maternity Services

Outpatient diagnostic and/or Emergency Department services provided ***in conjunction with a maternity-related diagnosis*** prior to the inpatient admission should not be included on the inpatient claim.

Section B - Applicable to Professional Services (1500 Claim Form)

Inpatient Preoperative Care

Preoperative care furnished by a provider three (3) days prior to an inpatient admission is considered included in the reimbursement for the inpatient services submitted by the admitting hospital (e.g. bundled service).

However, reimbursement may be permitted for unusual preoperative medical care or for medical treatment attempted to avoid an operation, even though surgery eventually was necessary. The Plan reserves the right to determine what medical care is acceptable to be reimbursed in these situations.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Highmark Provider Manual (Chapter 6, Unit 3)

REFERENCES:

- Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1
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POLICY UPDATE HISTORY INFORMATION:

11 / 2018	Implementation
11 / 2021	Added NY region applicable to the policy

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-039		
Subject:	Outpatient Services Prior To An Inpatient Admission		
Effective Date:	November 1, 2018	**End Date:**	
Issue Date:	November 1, 2018		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒		
Applicable Claim Type	**UB**	☒	**1500**	☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability.

PURPOSE:

This policy provides direction on The Plan's reimbursement related to outpatient services rendered prior to an inpatient admission. Such services include, but are not limited to, Emergency Department (ED), Observation (OBS) and Pre-Admission Testing (PAT).

The purpose of Pre-Admission Testing (PAT) is to ensure patients have no surgical contra-indications and the patient's physiological baseline is obtained prior to the performance of the procedure. PAT is done prior to scheduled procedures, including surgery or scheduled admissions. Testing may include blood or tissue analysis, radiological testing, cardiac diagnostics, respiratory status testing, etc.

BACKGROUND:

The Centers for Medicare & Medicaid Services applies a three (3) day rule, also known as the 72-hour rule, for services provided to outpatients who later are admitted as inpatients. According to the three (3) day rule:

- If an admitting hospital (or an entity wholly-owned, wholly-operated, or under arrangement with the admitting hospital) furnishes **diagnostic services** three days prior to and including the date of a beneficiary's inpatient admission, the services are considered inpatient services and are included in the inpatient payment (e.g. bundled service); **or**,
- If a hospital renders **non-diagnostic outpatient services** three days prior to, including the date of a beneficiary's inpatient admission, and the non-diagnostic outpatient services are **unrelated** to the inpatient admission, the hospital is permitted to separately bill for the non-diagnostic outpatient services (e.g. unbundled).

Note: If the **non-diagnostic outpatient services** are **related** to the inpatient admission, the services are considered inpatient services and are not separately reimbursable.

CMS DEFINITIONS:

Three-day window
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. (Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1)

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." (Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1)

Non-diagnostic outpatient service
A service not identified by a diagnostic service revenue code or CPT code. (American Medical Association, Current Procedural Terminology Manual)

REIMBURSEMENT GUIDELINES:

Section A - Applicable to Facility Services (UB-04 Claim Form)

The Plan's Commercial and Medicare Advantage products apply a policy similar to the Centers for Medicare & Medicaid Services (CMS) when outpatient services are performed at the **same** facility for a **related** diagnosis.

The guidelines shown below are applicable whether or not the member remains at the facility throughout the time period or leaves the facility and returns to be admitted within the time period.

Commercial and Medicare Advantage Products

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

The table below indicates the guidelines when outpatient services must be billed on the inpatient claim:

Scenario	If…	Then…
Member receiving Emergency Department (ED) services	a member receives ED services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.
Member receiving Observation services	a member receives Observation services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.

Member receiving Pre-Admission Testing or other Outpatient services	a member receives Pre-Admission Testing or other Outpatient services within a **3-day** period prior to an inpatient admission to the **same** facility for a **related** diagnosis…	**all** services shall be billed on the inpatient claim.

Excluded Services (Commercial Products Only)

Certain outpatient services are excluded from this policy when performed within the designated period prior to an inpatient admission. These services are not to be included on the inpatient claim and must be independently billed. Applicable services are as follows:

Chemotherapy and/or Outpatient Surgery
These services should not be included on the inpatient claim as long as they are ***not performed on the same day*** of the inpatient admission. If they are performed on the same day as the inpatient admission, then they must be included on the inpatient claim.

Maternity Services
Outpatient diagnostic and/or Emergency Department services provided ***in conjunction with a maternity-related diagnosis*** prior to the inpatient admission should not be included on the inpatient claim.

Section B - Applicable to Professional Services (1500 Claim Form)

Inpatient Preoperative Care

Preoperative care furnished by a provider three (3) days prior to an inpatient admission is considered included in the reimbursement for the inpatient services submitted by the admitting hospital (e.g. bundled service).

However, reimbursement may be permitted for unusual preoperative medical care or for medical treatment attempted to avoid an operation, even though surgery eventually was necessary. The Plan reserves the right to determine what medical care is acceptable to be reimbursed in these situations.

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Highmark Provider Manual (Chapter 6, Unit 3)

REFERENCES:

- Medicare Benefit Policy Manual, Chapter 6, Section 20.4.1
- Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, Section 90.7 and 90.7.1
- American Medical Association, Current Procedural Terminology Manual