Amerigroup RealSolutions in healthcare	**Reimbursement Policy**

Subject: Preadmission Services for Inpatient Stays		
Effective Date: **08/18/14**	Committee Approval Obtained: **06/24/20**	Section: **Facilities**

*****The most current version of the 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**. Under Quick Tools, select Reimbursement Policies > Medicaid. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement 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 These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements.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 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 day prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses, including: o Psychiatric hospitals and units. o Inpatient rehabilitation facilities and units. o Long-term care hospitals. o Children's hospitals. o Cancer hospitals. • For critical access hospitals (CAH), preadmission services are not subject to either the three-day or one-day payment window and, therefore, are separately reimbursable expenses from the inpatient stay reimbursement. • The three-day or one-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. Providers should append Modifier PD to diagnostic and nondiagnostic services that are subject to the preadmission payment window as indicated in Exhibit A: Modifier PD by Market. **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:

	○ Skilled nursing facilities ○ Home health agencies ○ Hospices • Unrelated nondiagnostic services **Note:** These services may be considered for separate outpatient reimbursement.
Exemptions	• Amerigroup Community Care in Maryland requires providers to bill outpatient preadmission services with the inpatient claim, although the services are separately reimbursed in accordance with the Health Services Cost Review Commission (HSCRC) guidelines. • Amerigroup Texas, Inc. and Amerigroup Insurance Company can use Modifier U4 to appeal unrelated services that are denied as part of the inpatient admission in accordance with the Texas Medicaid & Healthcare Partnership (TMHP). **Note:** Claims that are submitted with modifier U4 or condition code 51 will be subject to retrospective review and may be recouped if there is not sufficient documentation to indicate the service was unrelated to the inpatient admission
History	• Biennial review approved 06/24/20 • Effective 02/01/18: Policy template updated • Effective 09/01/17: Policy template updated • Biennial review approved 02/11/16: Language updated; Definitions section updated • Review approved and effective 08/18/14: Language updated; Texas exemption added; Definitions updated • Biennial review approved and effective 07/29/13: Policy template updated 07/24/13 • Modifier PD grid added 06/18/13: Background section/policy template updated • Review approved 03/12/12 and effective 07/11/12: Modifier PD requirement added per CMS update • Biennial review approved 12/05/11 and effective 09/28/07: Background section updated; Policy template updated • Review approved 08/30/10: Background section and Definitions updated; Policy template updated. • Review approved and effective 04/10/09: Policy change to adopt CMS guidelines versus 7 day payment window; Medical examples of diagnostic and nondiagnostic services removed; Maryland exemption clarified; Background section/policy template updated • Initial policy approval 05/31/07 with effective date of 09/28/07

References and Research Materials	This policy has been developed through consideration of the following: • CMS • State Medicaid • Amerigroup state contracts
Definitions	• **Admission-Related Outpatient Nondiagnostic Services**: services that are furnished in connection with the principal diagnosis assigned to the inpatient admission (CMS, Implementation of New Statutory Provision Pertaining to Medicare 3-Day Payment Window – Outpatient Services Treated as Inpatient, August 2010) • **Condition Code 51:** denotes attestation of Unrelated Outpatient Nondiagnostic Services • **Modifier PD:** indicates that the service is related to the inpatient admission • **General Reimbursement Policy Definitions**
Related Policies	• Modifier Usage • Transportation Services: Ambulance and Non-Emergent Transport
Related Materials	• None

Exhibit A: Modifier PD by Market*

Market	Applicable
Georgia	No
Maryland	Yes
New Jersey	No
Tennessee	Yes
Texas	Yes
Washington	No

* The use of Modifier PD may be superseded by provider contract.