Hospital Guidelines

For specific details regarding inpatient or outpatient services for behavioral health or chemical dependency please refer to our Behavioral Health Manual. The manual is available on our Web site www.wa.regence.com/provider or through your professional relations representative at 1-800-562-2156.

An **inpatient** hospital is a facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical) and rehabilitation services by or under the supervision of physicians, to patients admitted for a variety of medical conditions.

An **outpatient** facility is that portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. This part of the hospital may provide services in an emergency room or outpatient clinic and may offer ambulatory surgical procedures and/or medical supplies. They may perform laboratory tests that are billed by the hospital.

Billing Inpatient Vs. Outpatient Stays

Regence BlueShield uses the *Milliman Care Guidelines®* to determine appropriate level of care. Inpatient stays not meeting the inpatient criteria, may be rebilled as outpatient observation if the stay meets outpatient criteria. Members may remain as outpatients for up to 48 hours. When a stay is determined not to meet the *Milliman Care Guidelines®*, the facility may not balance-bill the member.

A member who is admitted from an outpatient or short stay unit and discharged on the same date of service is considered an outpatient.

The hospital must follow all established coding guidelines for inpatient and outpatient services, as outlined by the American Hospital Association, American Medical Association, Unified Hospital Data Discharge Set and the HealthCare Financing Authority), and by the National Uniform Billing Committee.

The date and time of the admission and discharge must appear on the UB-04 for all inpatient hospital claims, including those submitted electronically.

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Inpatient Services

Regence BlueShield pays for most inpatient hospitals on a per case basis. Regence BlueShield uses the All Patient DRG Grouper (AP-DRG). The following is an overview of this payment system.

AP-DRG Methodology

The following are included in the AP-DRG reimbursement:

- Coverage for room and board, including services and supplies
- Late discharges
- Fees for emergency or after-hours admissions
- Observational/outpatient charges
- Medical transport (excluding air ambulance)
- Diagnostic laboratory services
- Fees for any admitting or utilization review paperwork
- Discharge (take home) prescription drugs
- Preadmission services two days prior to admission and one day post discharge
- Emergency room if admitted

The majority of inpatient claims will be processed on an AP-DRG basis. Cases that are excluded from the AP-DRG methodology are:

- Transfer members
- Hospitalization during the time insurance becomes effective with Regence BlueShield
- Or any circumstances specified in the provider contracts.

Note: Any exceptions to the above will be specified in a hospitals current payment exhibit.

Inpatient Billing Guidelines

Inpatient-type institutional services provided to the member from the admission date to the discharge date (including pre-admit and emergency room work-up) will be covered as part of the AP-DRG payment, case rate and percent.

Inpatient hospital claims that are paid through the AP-DRG methodology are billed on an UB-04 claim form and exclude all professional components and air ambulance. Professional components, including pathology, radiology, anesthesia, emergency, etc., should be billed separately on a CMS-1500 claim form.

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Interim Bills

Interim bills will not be accepted. In order to properly adjudicate a claim paid on an AP-DRG basis, the member must be discharged.

Late Charges

Late submissions in general are not accepted. Providers must rebill an entire claim.

Itemized Statements

Regence BlueShield may require itemized statements as deemed necessary and appropriate.

Billing Guidelines for Pre-Admission Services

Medical Services uses a consistent set of guidelines during the audit of claims for incorrect billing of outpatient services related to an inpatient hospital admission. Outpatient diagnostic and non-diagnostic services related to an inpatient admission are included in the AP-DRG payment. These include services that are performed within two days prior to an admission and one day post-discharge.

Included service may be, but are not limited to:

- Autologous blood storage
- Charges incidental to the diagnostic studies, such as drugs, supplies, anesthesia and services of hospital personnel
- CT and MRI scans
- Diagnostic lab services
- Diagnostic or non-diagnostic services related to the inpatient admission
- Diagnostic testing on the day following discharge for the same diagnosis
- Diagnostic X-ray services
- EKG's and EEG's
- Nuclear medicine studies
- Observation or emergency care related to the inpatient admission
- Physical therapy prior to elective orthopedic surgery that is time-limited and specific for that procedure
- Pulmonary function studies
- Services occurring on the day of admission or within the stay for the same or related diagnosis

(Billing guidelines for Pre-Admission Services, Continued)

Services that are excluded from the above rule include:

- Ambulance services
- Ambulatory surgery followed by an inpatient stay (except the day of admission)
- Blood transfusions for chronic conditions (e.g., hemophilia, renal failure)
- Cardiac catheterization prior to coronary artery bypass
- Episodes of care that are repetitious in nature, but my be followed by an inpatient admission
- Home health
- Hospice
- Outpatient chemotherapy
- Physical therapy, occupational therapy, speech therapy and other types of rehabilitative therapy and respiratory therapy for a chronic or long-term condition
- Radiation therapy
- Renal dialysis
- Services unrelated to the inpatient stay
- Skilled nursing facilities

Outpatient Services

Outpatient surgery is reimbursed based on rate classifications. Regence BlueShield adopted Medicare's eight levels of classification for procedures performed in an outpatient setting. For procedures not classified by Medicare, Regence BlueShield classified these procedures using alphabetical designations. Procedures that have not been classified by either Medicare or Regence BlueShield may pay to a discount of billed charges (if the procedure qualifies for reimbursement).

Refer to your agreement for specific details regarding outpatient reimbursement that may differ from the above-mentioned process.

Note: *Outpatient prescription drugs are covered under a separate prescription drug benefit. Call provider customer service at* ***1-800-322-1737*** *for the members outpatient prescription drug benefit.*

High-Technology Services

Regence BlueShield will work with hospitals to identify high-technology services and supplies performed in an outpatient setting to establish appropriate billing protocols and standards for reimbursement.

Multiple Surgical Procedures

Surgeries that involve more than one procedure, the procedure with the highest reimbursement will be paid to the maximum allowable rate. The second procedure will be paid at 50% of the maximum allowable rate. There will be no additional reimbursement for the third and subsequent procedures.

(Outpatient Services, Cont.)

Services Included in the Facility Fee

The maximum allowable is intended to include, but is not limited to the following:

- Use of facility, including operating room, recovery and/or short stay rooms, prep areas, and use of waiting rooms and lounges created for members and relatives
- Administrative functions such as scheduling or cleaning, utilities and rent
- Nursing, technical staff, orderlies and others involved in member care connected to the procedure, intravenous therapy, and other related services
- Drugs (including take home), biologicals (blood), surgical dressings, supplies, splints, casts, appliances, non-custom braces, disposable infusion pain control pump, and equipment related to the provision of care
- Implants, including but not limited to the following; screws, plates, anchors, pins, and wires
- Diagnostic testing such as urinalysis, blood hemoglobin or hematocrit, pre-operative chest x-ray, and therapeutic items and services directly related to the procedure/service
- Anesthetic and any materials, disposable or re-useable, needed to administer anesthesia
- Intraocular lenses for insertion during or after cataract surgery

Services Not Included in the Facility Fee

These items should be **billed separately** from the facility fee with appropriate CPT® coding and/or Regence BlueShield designated codes:

- Physician's and other individually contracted provider services, including anesthesia
- The sale, lease or rental of durable medical equipment to ASC members for use in their homes
- Leg, arm, back and neck custom braces
- Artificial legs, arms and eyes
- Services furnished by an independent laboratory
- Ambulance services
- The technical component of radiological services related to the surgical procedure(s)
- Prosthetic devices defined as those items that are permanent replacements to existing body parts. Invoices are to be submitted upon request. Shipping and handling are not separately reimbursed

Emergency Room Services

Most contracts include an emergency room copay that may be collected at the time services are rendered. This copay is waived in certain circumstances, such as when the member is admitted to inpatient care directly from the emergency room. All services provided in the emergency room in conjunction with an inpatient hospital stay should be billed on the inpatient hospital claim.

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Billing Guidelines for Outpatient Care

1. All outpatient services, as defined below, will require submission of current CPT® coding on the UB-04 form.
2. Professional services that are billed on the CMS-1500 form are not affected and should continue to be billed on the CMS-1500.
3. Reimbursement for outpatient services is based upon a maximum allowable fee schedule (if submitted charges are less than the fee schedule, Regence will reimburse at the charged amount).
4. For services in which a CPT® code is available but not submitted, claims will be returned to the hospital for resubmission using the required CPT® codes
5. Outpatient bills on the same date of service for the same member must be billed together as one claim, similar to inpatient claims. Regence BlueShield will not accept interim bills on outpatient services, with the exception of monthly billing for rehabilitative services.
6. One procedure equals one unit of service (exception: laboratory, radiology, mental health services, and physical therapy services).
7. Outpatient services will be subject to identical requirements for all outpatient providers (e.g., correct coding initiative).

Rehabilitation Services

Services for rehabilitative care, when it is medically necessary to restore and improve function previously normal but lost due to illness or injury are covered. If a child was covered from birth on a Regence BlueShield health plan, rehabilitation services for congenital anomalies may be covered.

Rehabilitation services for an inpatient or on an outpatient basis, are eligible for reimbursement for physical, speech, and occupational therapy to a specific dollar amount per condition. For specific information on your member's benefits, please call provider customer service at **1-800-322-1737**. Some contracts may require prior approval. In order to receive reimbursement for rehabilitative services the hospital must be approved for these services.

Services or items not covered:

- Custodial care, maintenance
- Non-medical self-help
- Recreational, education or vocational therapy
- Learning disabilities, attention deficit disorders or development delay
- Chemical dependency rehabilitative treatment
- Gym or swim therapy
- Hippo therapy

Aqua and/or hippo therapy may be covered under some contracts if specific criteria are met.

***Note**: All claims must be submitted with the referring physician's name.*

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Medical Management

Services and supplies that are eligible for reimbursement must be medically necessary, as defined in the medical policies.

Examples of medical management responsibilities may include but are not limited to, the following:

- Preadmission review to determine whether a scheduled inpatient admission is medically necessary
- Admission review to determine whether an unscheduled inpatient admission or an admission not subject to preadmission review is medically necessary
- Concurrent review to determine whether a continued inpatient admission is medically necessary, including the management of member care by suggesting alternative sites and methods of care
- Length-of-stay review to assign the number of inpatient days appropriate for an inpatient stay
- Retrospective review to determine whether services and supplies were medically necessary, including the assignment of appropriate diagnostic and procedure codes
- Case management to coordinate the care for members whose medical needs are extensive and usually longer term, when applicable
- Review of the hospital's health care practices and utilization patterns
- Utilization guidelines to determine appropriate rendering of health-care services
- Collaboration with Regence BlueShield on clinical guidelines/pathways and disease management programs
- On-site Regence BlueShield reviewers who will have access from the provider and appropriate personnel to chart documents to appropriate personnel to assure the above. Concurrent reviewers will have access to charts and members as needed on the nursing floors. Retrospective and quality reviewers will have access to chart documents in the provider's medical records department. Regence BlueShield's reviewers will make the best effort to work with the provider and to audit policies.
- Quality improvement activities that support credentialing, recredentialing clinical and service studies and other medical management functions

Hospital Guidelines

Retrospective AP-DRG Audits

The Retrospective Review Department at Regence BlueShield was developed to ensure accuracy and appropriateness of reimbursement. One of the many functions of the Retrospective Review Department is post-payment auditing.

Audits focus on the following, including but not limited to:

- AP-DRG review
- Preadmission services audits
- Ambulatory surgery audits

Audit Basics

- Correspondence confirming audit date and cases to be reviewed will be faxed or mailed within ten working days of the audit.
- If a coding discrepancy is identified on a claim, a letter will be mailed to the hospital that will include suggested coding changes as well as the auditor's rationale.
- The hospital has 30 days from the date of the audit letter to appeal any Regence BlueShield determinations.
- If a dispute is not received by the 30-day deadline, Regence BlueShield will adjust the claim according to the auditor's final determination.

Nationally recognized criteria are used to determine if services were provided at the appropriate level of care. If an admission does not meet inpatient criteria, the auditor will send a letter suggesting the hospital's utilization review department review the case. If no response is received from the hospital within 30 days, the claim will be adjusted with the message code U25 (*Medical necessity for inpatient stay not met per criteria. Determination made after facility review*).

If the admission meets observation criteria, hospitals may do one of three things:

- Resubmit as a corrected billing using the corrected observation status
- Accept the denial of inpatient status

Any corrected billing should be submitted as a hard copy claim within one year of the audit date.

The hospital agreement with Regence BlueShield states, that facilities may not bill the member for any service or supply deemed not medically necessary, or for any reimbursement differences that result from an AP-DRG assignment correction.

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AP-DRG Review Program

Regence BlueShield auditors include registered health information technicians, registered health information administrators and registered nurses trained in ICD-9-CM coding. Auditors perform medical record reviews to identify the following:

- Accuracy of the AP-DRG assignment based on the documentation contained in the medical record at the time of the review
- Inappropriate inpatient admissions
- Readmissions within two days
  - When a hospital agrees to the new DRG weights, Regence BlueShield will no longer review for a readmission within 48 hours of discharge for related conditions.

In AP-DRG reviews, auditors use nationally accepted coding guidelines published by the American Hospital Association in Coding Clinic, along with supplementary guidelines that are available from other nationally recognized organizations.

Pre-admission Outpatient Services

Claims processing system edits are in place to capture claims for outpatient services that are provided two days before a related inpatient admission and within one day after hospital discharge. Auditing is performed on a post-pay basis.

Claims for outpatient diagnostic and non-diagnostic services billed within the two-day pre-admission and one-day post-discharge time frame will be re-processed by Regence BlueShield auditors with message code W51 (*Charges are included in DRG payment amount. Member is not responsible for charge*). Notification of this reimbursement determination is communicated on payment vouchers.

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Line-by-Line Bill Audit Program

Both pre-payment and post-payment claims reviews are conducted to ensure correct reimbursement and contract compliance. Audits on claims that fall into an AP-DRG outlier status and claims that pay to a percentage of billed charges are reviewed.

The two types of audits are performed:

1. Desk audits: Adjustments are initiated based on contractual denials such as rental/ reusable equipment, and unbundled supplies/services that are included in the daily room charge.
2. On site audits: The medical record is requested and reviewed at the facility to determine if the documentation supports charges on the itemized bill.

By expanding our ability to identify incorrect coding and billing practices, we can assist facility administrative staff in adopting billing methods that will result in more accurate and consistent reimbursement by identifying incorrect coding and billing practices. Auditors will review claims for accuracy of charges and description of services, overpayments and underpayments.

Line-by-line audits will also focus on:

- Corrective coding of charges
- Services/supplies considered non-covered
- High-cost services and supplies

The following guidelines are used during an audit:

Non-Allowable Charges Include But Are Not Limited to the Following:

- Re-useable/rental equipment (i.e., infusion devices, feeding pumps, SCD, and surgical instruments)
- Routine supplies that are included in the cost of the room where services were provided (i.e., surgical gowns, gloves, masks, irrigation solutions, oxygen supplies, and syringes)
- Added fees charged for non-routine handling of laboratory specimens processed within the facility (i.e., STAT fees)

Hospital Guidelines

(Line by Line Audit Program, Cont.)

Room and Board Charges Include But Are Not Limited to the Following

- All nursing staff services including but not limited to coordinating the delivery of care, member education, and supervising the performance of other staff members to whom they have delegated member care activities
- Room and complete linen service-surgical instruments
- Dietary service including all meals, therapeutic diets, required nourishment, dietary supplements and dietary consultation
- Thermometers, blood pressure apparatus, gloves, tongue blades, cotton balls and other similar items used in the examination of members
- Use of examination and/or treatment rooms
- Supplies provided as part of routine care including, but not limited to: wipes, swabs, scales, bed pan, bedside commode, breast pump, and personal care items (i.e., lotion, shampoo, soap, and member gowns)
- Administration of medications including IVs
- Labor care and postpartum services
- Recreation therapy
- Interpretation or reading of member monitoring (i.e., pulse oximetry and fetal monitoring)
- Incremental nursing charges (ER, OB, nursery, critical care, OR, etc.)

As part of the claims review process, we may request the following: The itemized bill, the medical record, and the documentation supporting charges for implants, including invoices.

If discrepancies are identified, we will mail a letter including a summary of our findings, to the hospital within 10 days of the completion of the audit. The hospital has 30 days from the date of the audit letter to dispute any Regence BlueShield determinations. If a dispute is received by the 30-day deadline, Regence BlueShield will adjust the claim according to the auditor's findings.

Per the hospital contract with Regence BlueShield, facilities may not bill the member for any reimbursement differences that result from an audit.