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Reimbursement Policy

Preadmission Services for Inpatient Stays

Policy Number: **G-01017**

Policy Section: **Facilities**

Last Approval Date: **9/11/2025**

Effective Date: **9/11/2025**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to <https://anthem.com/provider>.

Policy

The health plan allows reimbursement for applicable services 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.

Reimbursement is 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 the following 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:

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- Psychiatric hospitals and units
- Inpatient rehabilitation facilities and units
- Long-term care hospitals
- Children's hospitals
- 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.

Outside Payment Window

The health plan does not consider the following services to be included in the payment window prior to an inpatient stay for preadmission services:

- Ambulance services
- Donor post-kidney transplant complications 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.

Related Coding

Standard correct coding applies.

Definitions

- Admission Related Outpatient Nondiagnostic Services - Services that are furnished in connection with the principal diagnosis assigned to the inpatient admission

- Condition Code 51 - Denotes attestation of unrelated outpatient non-diagnostic services
- Modifier PD - Indicates that the service is related to the inpatient admission
- General Reimbursement Policy Definitions

Related Policies and Materials

- Documentation Standards for Episodes of Care
- Modifier Usage
- Transportation Services: Ambulance and Non-Emergent Transport

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- State contract

Policy History

- **09/11/2025** - Review approved and effective: no changes
- **12/11/2023** - Review approved and effective: no changes
- **01/01/2020** - Update due to regulatory directive: Donor post-kidney transplant complication services added to Outside Payment Window policy section.
- **08/03/2018** - Review approved: Policy template updated
- **04/06/2018** - Review approved and effective: Nonreimbursable section renamed to Outside Payment Window
- **02/11/2016** - Review approved: removed “applicable” for language simplification; Definitions section updated
- **01/01/2015** - Initial approval and effective

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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