SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Member Provider Policy & Procedure Manual

5.13 INPATIENT

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Member Provider Policy & Procedure Manual*. If Blue Cross and Blue Shield of Louisiana (Louisiana Blue) makes any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Member Provider Policy & Procedure Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Member Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail our policies. Louisiana Blue retains the right to add to, delete from and otherwise modify the *Member Provider Policy & Procedure Manual* as needed. This manual and other information and materials provided are proprietary and confidential and may constitute trade secrets.

INPATIENT

Admissions Through the Emergency Room/Observations

When a patient is in observation status or in the emergency room affiliated with the acute care facility and is subsequently admitted to the affiliated acute facility, the observation and/or emergency room record should become part of the affiliated acute facility admission record and the associated charges should be included when billing the inpatient claim. This is the case for one or multiple emergency room visits in the same day or across two days. Thus, if there is a subsequent inpatient admission, the emergency room visit(s) and/or observation should be filed with the inpatient hospital claim and will be included in the inpatient stay. The admission date should reflect the date when the patient was admitted in the acute facility. These rules apply regardless of whether the emergency room is physically located on the same campus as the affiliated acute facility or off campus of the affiliated acute facility.

MS-DRG Validation/ICD-10-CM Code Editing

We will edit the hospital's coding, upon claims submission, for accuracy and internal consistency. Such editing may require Louisiana Blue to return the claim to the hospital for correction of the coding.

Implantable Devices

Louisiana Blue will review claims for consideration of additional reimbursement on dispute for inpatient procedures involving implantable devices when the following are met:

- The invoice cost of the device is equal to or greater than $12,000.
- The total charges do not exceed the outlier threshold.
- The case rate reimbursement does not apply as defined in the Reimbursement Appendix of the Member Provider Agreement.
- Diagnosis-related group (DRG) case rates do not apply.

Member Providers who have claims that meet the above thresholds who do not agree with the reimbursement should contact Provider Disputes at the information found in our Quick Reference Guide in the front of this manual to have the claims reviewed.

Note: When total charges for inpatient procedures involving implantable devices exceed the outlier threshold, the claim will not be eligible for additional reimbursement because additional reimbursement would have been paid under the outlier provision as outlined in the Reimbursement Appendix of your Member Provider Agreement.

DME, Prosthetic and Orthotic Equipment and Device Recalls

There is no coverage for durable medical equipment (DME), prosthetic and orthotic equipment and devices that are being or have been recalled and are under five years of age. Recalled DME, prosthetic and orthotic equipment and devices that are under five years of age must be replaced at no charge to the member or Louisiana Blue.

We will allow reimbursement of medically necessary procedures to remove and replace recalled or replaced devices. Louisiana Blue will not be responsible for the full cost of a replaced device if an inpatient or outpatient facility is receiving a partial or full credit for a device due to recall. Reimbursement will be reduced by the amount of the device credit.

Interim Bills

Louisiana Blue does not accept interim billings for inpatient services. Institutional claims must be submitted with a bill type. The first digit of the bill type indicates the type of facility. There are no exclusions related to the first digit of the bill type. The second digit of the bill type indicates the bill classification. There are no exclusions related to the second digit of the bill type. The third digit of the bill type indicates the frequency. There **are** limitations and exclusions related to the frequency digit. **Louisiana Blue will not accept bill types with a frequency code of 4, 5, 6 or 9.** Interim bills and late charge claims should be aggregated into one final claim for submission and be submitted using a frequency code of 1 or 7. Use frequency code of 8 for void claims. For illustrative purposes, we provide further clarification in the chart below.

Frequency Code	Description	Louisiana Blue Acceptance Rule
Non-interim Claims		
1	Admit Through Discharge Claim	Accepted
Interim Claims		
2	Interim (First Claim)	We accept interim claims only when the total charge is $800,000 or greater **and** the length of stay is at least 60 days of service
3	Interim (Continuing Claims)	
Not Accepted		
4	Interim (Last Claim)	Not Accepted
5	Late Charge Only	Not Accepted
6		Not Accepted
9	Final Claim for a Home Health PPS Episode	Not Accepted
Prior Claims		
7	Replacement of Prior Claim or Corrected Claim	Accepted
8	Void or Cancel of a Prior Claim	Accepted

Inpatient interim and late charges normally billed with bill types ending in 2 or 3 would need to be aggregated with any additional bills to produce a final bill with all services and charges included and a bill type with a frequency code of 1 or 7. Failure to follow these guidelines will result in returned or denied claims.

Exception: An interim bill will be accepted only when the total charge is $800,000 or greater and at least 60 days of service.

Mother and Newborn Claims

The hospital must submit combined billings for mothers and newborns who are discharged on the same date or newborns discharged before mothers. Maternity per diem and DRG case rates have been developed with this consideration. Maternity per diems are inclusive of singleton and/or multiple deliveries.

For Federal Employee Program (FEP) members, when billing the newborn's claim with a Neonatal Intensive Care Unit (NICU) revenue code, it must be filed separately from the mother's claim.

Sick (Boarder) Baby Billing Protocol

Upon delivery of a newborn, if the baby's discharge date is **prior to or equal to the mother's discharge date**, the newborn's charges are generally combined with the mother's inpatient hospital claim.

If the baby is sick and the discharge date is **after mother's discharge date**, the sick (boarder) baby charges should be filed as a separate claim.

- These charges should not be combined with the mother's claim. The admit date of the baby's claim should be the baby's date of birth, not the mother's discharge date.
- The facility should request a "temporary" authorization for the baby's stay under "baby girl" or "baby boy." A temporary authorization can be requested within 48 hours of admission or when mom is discharged.

Effective April 1, 2021, if the baby is sick and transferred to another facility on or before mother's discharge date, the sick baby charges can be filed as a separate claim.

Organ Transplant Services

Inpatient stays involving transplants of heart, heart-lung, lung, liver, kidney, pancreas or bone marrow require prior written authorization from Plan based on the member contract/certificate and requirements of Louisiana Blue. In the absence of a global pricing reimbursement arrangement, inpatient hospital reimbursement provisions apply.

Patient Expired

The date the patient expired is treated as the date of discharge.

Preadmission Testing Billing

All outpatient services provided within 72 hours prior to admission, including preadmission testing, are included in the reimbursement amount for the inpatient stay and must be billed as part of the inpatient claim. This provision applies only to outpatient services performed at the same or an affiliated facility where the patient is subsequently admitted.

National Provider Identifier Usage

Member Providers should submit the appropriate NPI number in Block 56 on the UB-04 claim form to ensure payment is made accurately and on time.

Readmissions Policy

Reimbursement rates are set at the average cost to treat the condition and fully reimburse a facility for treatment of the condition. If the patient returns within the timeframes listed below with the same condition, a similar condition or a complication of the original condition, then the original payment is full reimbursement for treatment of the original condition and any complications.

Readmissions to the same or affiliated facility for the same condition, similar condition or a complication of the original condition within 30 days of discharge will not be reimbursed, as the original payment is full reimbursement for treatment of the original condition and any complications.

Providers cannot bill members for services recouped as a result of this policy.

Effective Aug. 1, 2024, we will audit readmissions to the same or affiliated facility for the same condition, similar condition or a complication of the original condition within 30 days of discharge when the patient is discharged from the first admission to home or home health.

We use the Healthcare Effectiveness Data and Information Set (HEDIS®) Plan All-Cause Readmissions algorithm to flag readmissions for exclusion from the Readmissions Policy. Most conditions excluded from the HEDIS All-Cause Readmissions measure are also excluded from this policy.

Cases will be excluded from the policy if the admission was related to:

- Chemotherapy*
- Children under 18 years of age
- Leaving against medical advice on the original admission
- Medicaid
- Medicare critical access hospitals
- Non-acute facility
- Organ transplant*
- Potentially planned procedures*
- Rehabilitation*
- Sickle Cell Disease

**Louisiana Blue uses the HEDIS Plan All-Cause Readmissions algorithm to help identify the exclusions mentioned above.*

Sepsis

Louisiana Blue conducts clinical validation to ensure the accuracy of diagnosis and procedure codes and DRG assignment for all inpatient DRG claims. Our reviewers (including our vendors) use evidence-based clinical guidelines from nationally recognized sources (current and widely accepted Sepsis-3 criteria) to clinically evaluate medical records. DRG validation of clinical records allows us to confirm that clinical evidence supports the codes billed on a claim and reflects the clinical scenario for Sepsis-3. Louisiana Blue requires all claims for payment to include diagnoses that can be clinically validated in the medical record documentation. The Sepsis-3 definitions, published in 2016, are the global standard for diagnosing sepsis. They define sepsis as life-threatening organ dysfunction caused by a dysregulated host response to infection, using the Sequential Organ Failure Assessment (SOFA) score to quantify organ dysfunction.

Transfers In

Transfers In are treated as regular admissions and are subject to medical necessity review.

Transfers Out

Transfers Out are subject to medical necessity review and eligible for outlier payment only if the hospital initiates concurrent review procedures with Louisiana Blue.