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Hospital Related Services for Outpatient Claims

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY. THE EFFECTIVE DATE OF THIS POLICY IS FOR THE PUBLICATION DATE OF THE POLICY ONLY AS THIS POLICY IS BASED ON PARTICIPATING HOSPITAL AGREEMENTS AND HAS BEEN APPLIED THROUGH HEALTHCARE PROVIDER AUDIT AND OTHER MEANS UP TO THE PUBLICATION OF THIS POLICY.

DESCRIPTION:

This policy applies to Florida Blue Commercial and Medicare Advantage outpatient hospital claims. It is based on provider contract language for outpatient payment programs and information in the provider manual.

Just as inpatient admissions can have outpatient services performed prior to the admission that should be billed on the inpatient claim, there are instances where outpatient related services performed within 3 days of another outpatient claim for treatment/services should be billed as a single claim. Or in the case of pre-operative testing, which should be billed on the outpatient surgical claim performed with 7 days of the testing.

REIMBURSEMENT INFORMATION:

Related services billing applies to any episode of care that is performed on the same day or spans multiple dates of service (e.g., Observation, ER, PTCA, Electrophysiological Studies).

Series billing for Chemotherapy, Radiation, Infusion, Physical Therapy, Speech Therapy, Occupational Therapy, Cardiac Rehabilitation, Hyperbaric Oxygen or Behavioral Health Treatment should be submitted based on historical billing practices. If serial billing has been traditionally done on a weekly, bi-weekly, or monthly basis, Florida Blue would expect that claims continue to be submitted in this manner.

Florida Blue will deny the second outpatient claim upon initial submission if an outpatient claim has been reimbursed and is determined to be related to a prior outpatient claim. The outpatient claim will have claim history checked 3 days (7 days for pre-operative testing) prior to the "from date" for the outpatient

claim and 3 days from the “through date” of the outpatient claim in case claims are not processed in order of the claims’ dates of service. The second outpatient claim being adjudicated will be denied indicating a single bill is required for all services.

Hospitals may reference their participation agreement or the Florida Blue Manual for Physicians and Providers to determine the timeframe applicable for billing outpatient related services as a single claim or for billing pre-operative testing on the claim for the surgery.

Additionally, as is consistent with industry standard billing practices, any outpatient services performed continuously without the patient being discharged should be submitted as a single claim. For example, the patient is transferred from the emergency room setting to an observation setting without being discharged and treatment spanned over 3 days.

BILLING AND CODING:

Any outpatient services performed, regardless of revenue center, that are for the same or a related condition, should be submitted as a single claim unless documentation can be provided to support that the services are for separate or unrelated episodes of care.

If multiple diagnostic imaging services are performed within a 72-hour period (3 days), a single claim should be submitted if the imaging services are being performed for the same condition or are for the same anatomical region.

If other outpatient services occur on the same day as a series billed service, both the outpatient service and the series billed service should be submitted on the same claim. A separate claim should be submitted for any remaining serial services that occurred within the same billing period (e.g., weekly, bi-weekly, monthly). Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures.

Revenue codes considered as pre-operative testing when billed by themselves or together:

Revenue Code	Description
030X	Laboratory, urinalysis
032X	Radiology diagnostic
073X	EKG/ECG

RELATED PAYMENT POLICIES:

N/A

REFERENCES:
N/A

GUIDELINE UPDATE INFORMATION:

12/08/2022	New Policy
12/08/2023	Annual Review, series billing services list, grammatical corrections
12/12/2024	Annual Review no changes