



PAYMENT POLICY		
Preadmission Services		
Original Date Approved	Effective Date	Revision Date
2/5/2025	7/1/2025	
Applies to Products:		
☒ Senior Care Options MA ☒ One Care MA		

PAYMENT POLICY STATEMENT:

Commonwealth Care Alliance, Inc. (CCA) has established a payment policy that defines preadmission services rendered by hospitals for all products and is aligned with state and federal guidelines.

DEFINITIONS:

Hospital: An institution in which sick or injured individuals are given medical or surgical treatment.

Inpatient Prospective Payment System (IPPS): A payment system used to reimburse hospitals for inpatient stays using a fixed rate determined by the patient's diagnosis and treatment by Diagnosis-Related Groups (DRG) classification.

Current Procedural Terminology (CPT): A numerical or alphanumeric five-digit code used to classify medical services and procedures to help report information more accurately and efficiently.

Healthcare Common Procedure Coding System (HCPCS): (Also known as HCPCS Level II) An alphanumeric code starting with an alphabetical letter followed by 4 numeric digits; it is used to identify medical related products, supplies, and services not included in the CPTS codes for billing purposes.

Revenue Codes: A 4-digit number that is used on facility claims to tell where the patient was when they received treatment, or what type of item a patient may have received.

Type of Bill (TOB): A 3-digit numeric code located on an institutional/facility claim that describes the type of facility, type of care, and episode of care (frequency) for the services rendered.

Modifier: A two-digit alphabetic, numeric, or alphanumeric code used to indicate a specific circumstance that altered a procedure or service without changing its definition or code and provides more information about the procedure or service performed.

CMS-1450: (also known as UB-04) Claim form used for institutional (facility) services.



AUTHORIZATION REQUIREMENTS (If applicable):

N/A

REIMBURSEMENT GUIDELINES:

CCA follows state and federal guidelines and policies for preadmission services. Preadmission services are diagnostic and non-diagnostic outpatient services that are rendered within a 3-day payment window prior to an inpatient admission. The 3-day window includes the services rendered on the date of admission and the 3 calendar days preceding the date of admission (not to exceed 72 hours). For non-IPPS hospital types (listed below), they are subject to a 1-day payment window prior to the inpatient admission, which includes services rendered on date of admission and the entire calendar day preceding the date of admission (not to exceed 24 hours). **NOTE: Critical Access Hospitals (CAH) are not subject to preadmission conditions unless the admitting hospital is a short stay acute hospital paid under IPPS or admitting hospital is one of the non-IPPS hospital types listed below:**

- Psychiatric Hospital
- Inpatient Rehabilitation Hospital
- Long-term Care Hospital
- Children's Hospital
- Cancer Hospital

All diagnostic and non-diagnostic outpatient services provided prior to inpatient admission are considered bundled services and are not paid separately from inpatient services. These services must be included on the inpatient claim using an inpatient type of bill (TOB). The payment for the outpatient diagnostic/non-diagnostic services billed on the inpatient claim will be included in the inpatient reimbursement to the facility using the compensation outlined in the facility's contractual agreement with CCA. Any preadmission claims where the services result in inpatient admission that are billed separately from the inpatient claim will be denied.

Non-diagnostic/therapeutic codes classified as preadmission services must be related to the inpatient admission and are not necessarily required to have the same diagnoses as the inpatient services. Ambulance services and renal dialysis services are not included as part of the preadmission service bundle. For non-diagnostic services unrelated to inpatient admission, please follow billing guidelines outlined in the CMS Inpatient Hospital Billing Medicare Claims Processing Manual.

Outpatient diagnostic are services (examinations, tests, procedures) provided to a patient in order to obtain information to aid in the assessment of a medical condition or identification of a disease. Below is the list of diagnostic services classified as preadmission services:

Rev Code	Description
0254	Pharmacy; Drugs incident to other diagnostic services



0255	Pharmacy; Drugs incident to radiology
030X	Laboratory
031X	Laboratory Pathology
032X	Radiology Diagnostic
0341	Nuclear Medicine; Diagnostic
0343	Nuclear Medicine; Diagnostic radiopharmaceuticals
035X	CT Scan
0371	Anesthesia; Incident to radiology
0372	Anesthesia; Incident to other diagnostic services
040X	Other Imaging Services
046X	Pulmonary Function
0471	Audiology; Diagnostic
0481	Cardiology; Cardiac cath lab with CPT codes 93451-93464, 93503, 93505, 93593-93597, 93563-93568, 93571-93572, 93598, and G0278
0482	Cardiology; Stress test
0483	Cardiology; Echocardiology
0489	Cardiology; Other with CPT codes 93451-93464, 93503, 93505, 93593-93597, 93563-93568, 93571-93572, 93598, and G0278
053X	Osteopathic Services
061X	Magnetic Resonance Technology (MRT)
0621	Medical/Surgical Supplies; Incident to radiology
0622	Medical/Surgical Supplies; Incident to other diagnostic services
073X	EKG/ECG Electrocardiogram
074X	EEG Electroencephalogram
0918	Behavioral Health Treatments/Services; Testing
092X	Other Diagnostic Services

RELATED SERVICE POLICIES:

Observation Services

AUDIT and DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, CCA has the right to expect the provider/facility to refund all payments related to non-compliance. CCA reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

REFERENCES:



CMS Medicare Claims Processing Manual, Chapter 3 - Inpatient Hospital Billing
<https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf>

CMS Three Day Payment Window
<https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/three-day-payment-window>

CMS Frequently Asked Questions CR 7502 Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients
<https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/downloads/cr7502-faq.pdf>

MassHealth 130 CMR 410 Acute Outpatient Hospital Manual
<https://www.mass.gov/doc/acute-outpatient-hospital/download>

POLICY TIMELINE DETAILS:

1. Approved: February 5, 2025