If a conflict arises between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. If a conflict arises between a CPCP and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern. "Plan documents" include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of Oklahoma may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSOK has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology, CPT® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Outpatient Facility Service(s) Overlapping During an Inpatient Stay

Policy Number: CPCP039

Version 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: June 12, 2025

Plan Effective Date: June 20, 2025

Description

The purpose of this policy is to address claims submitted with outpatient service dates that fall entirely within or overlap with an inpatient admission. This policy is not intended to address every reimbursement situation that may arise.

Facilities should verify a member's eligibility at the time of or prior to admission to ensure the member is eligible to receive services.

Reimbursement Information

The Plan reserves the right to request supporting documentation. Failure to adhere to coding and billing policies may impact claims processing and reimbursement. Additionally, the plan will recover reimbursement of previously paid claims where dates of services overlap an inpatient admission as described below.

Outpatient service dates that fall completely **within** inpatient admission and discharge dates, by the same or another facility are not eligible for separate reimbursement. A facility cannot separately bill for outpatient services that were rendered while the member was inpatient. **Note**, qualified healthcare professional services billed on a professional claim while the member is admitted as an inpatient, using an inpatient place of service code, may be eligible for separate reimbursement.

Unless otherwise specified in the facility's contract or the members' plan documents, outpatient services provided during a member's inpatient facility admission should be billed by the inpatient facility, and not by a third party (e.g., member is sent to another location for a test or service by the inpatient facility where the member is currently admitted). Unless otherwise specified in the facility's contract or members' plan documents, services provided by a third party while the member is admitted to the facility are the responsibility of that facility and should be included on the inpatient admission claim. If a claim for outpatient services is submitted while the member is inpatient, the inpatient facility must submit a corrected claim for those services under the inpatient stay. Information on how to submit a corrected claim submission is included in the *Additional Resources* section of the policy below.

Examples

Claim Example:

- Claim 1 is bill type 11X (hospital inpatient) for inpatient admission dates of service 02/01/2022 – 02/08/2022.

- Claim 2 is bill type 13X (hospital outpatient) for outpatient services for date of service 02/04/2022.

Claim 2 is not eligible for reimbursement because all of the services the member received while inpatient should have been reported on the inpatient claim.

Overlap with a Skilled Nursing Facility (SNF) Example:

The facility should ensure they have submitted the correct admit and discharge dates on their claim.

- **For example**, overlapping may occur where a SNF has failed to properly discharge the patient while the patient was admitted to a hospital. The facility should submit the correct discharge patient status code on the claim. Additionally, if the patient was transferred from a SNF prior to midnight, the hospital must bill a *Same Day Transfer*.

Exclusions

There may be instances where a specific service is contractually eligible for separate reimbursement. Facilities should review their contract and other plan documents to determine eligible reimbursement.

Additional Resources

Electronic Replacement/Corrected Claim Submission

Clinical Payment and Coding Policy
CPCP002 Inpatient/Outpatient Unbundling Policy- Facility
CPCP024 Evaluation and Management (E/M) Coding- Professional Provider
CPCP038 Outpatient Services Prior to an Inpatient Admission

References

CMS 0072- Outpatient Service Overlapping or During Inpatient Stay: Duplicate Payments, Accessed April 9, 2025

Policy Update History

05/09/2023	New policy
06/25/2024	Annual Review
06/12/2025	Annual Review; Grammatical & formatting updates; Additional Resources & References updated.