Overlapping Services While Inpatient

Reimbursement Policy ID: RPC.0078.72KF

Recent review date: 10/2025

Next review date: 11/2027

Keystone First Community HealthChoices reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First Community HealthChoices may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy outlines the circumstances that may prompt Keystone First Community HealthChoices to deny reimbursement of claims for services, supplies, or equipment reported with a date of service that falls within (i.e., overlaps) the date span of an inpatient stay.

Exceptions

For Keystone First Community HealthChoices members receiving Long-Term Support Services (LTSS), the following items and services are exempt this policy:

- Services and supplies represented by HCPCS codes: 97537, S5121-UD, W0139, W0140, W0141, W1011, W1894, W1895, W7332, W7333, W7334, W7335, W7336, W7337, W7337-RE, W7337-TR.

- Regular monthly delivery of meals and/or incontinence supplies.

Outpatient services, supplies, and equipment reported on the dates of admission or discharge for an inpatient stay are excluded from this policy.

Reimbursement Guidelines

Keystone First Community HealthChoices will reimburse professional, and facility claims according to the provider's contract and applicable section(s) of the Keystone First Community HealthChoices provider manual.

All services reported to Keystone First Community HealthChoices must be supported in the medical record. Keystone First Community HealthChoices may request medical records from billing providers when claim data suggests a possible overlap in services. Claims identified as potentially overlapping services will be reviewed and medical records may be requested for the following services:

- Professional or outpatient facility services performed on date(s) of services that overlap an inpatient facility stay.
- Home health service claims rendered in the member's home with date(s) of service that overlap an inpatient facility stay. Home health services are not reimbursed while a patient is in an inpatient facility.
- DME equipment and/or supplies reported with date(s) of service that overlap an inpatient facility stay.

Definitions

Durable Medical Equipment (DME)
DME is equipment that can withstand repeated use (at least 3 years) and is used in the home for medical reasons when someone is sick or injured.

Home Health Care
Medical care delivered in the patient's home, if the patient is homebound while recovering from an illness, surgery or injury or has a chronic medical condition.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare & Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI) in Medicaid.
VI. Corresponding Keystone First Community HealthChoices Clinical Policies.
VII. Pennsylvania Medicaid Fee Schedule(s).

Attachments

N/A

Associated Policies

RPC.0074.72KF Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Policy History

10/2025	Reimbursement Policy Committee Approval
09/2025	Biennial Review • No major updates
04/2024	Revised preamble
03/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by Keystone First Community HealthChoices from Policy History section
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section