Qualified Health Plans offered in North Carolina by CareSource North Carolina Co., d/b/a CareSource

ADMINISTRATIVE POLICY STATEMENT
North Carolina Marketplace

Policy Name & Number	Date Effective
Three-Day Window Payment-NC-MP-AD-1270	01/01/2023-07/31/2023
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject....2
B. Background....2
C. Definitions....2
D. Policy....2
E. Conditions of Coverage....3
F. Related Policies/Rules....3
G. Review/Revision History....3
H. References....3

Archived

A. Subject

Three-Day Window Payment

B. Background

CareSource follows the three-day window payment policy as established by the Centers for Medicare & Medicaid Services (CMS). According to the three-day rule, if an admitting hospital (or wholly owned or wholly operated physician practice) provides diagnostic or nondiagnostic services three days prior to and including the date of the member's inpatient admission, the services are considered inpatient services and are included in the inpatient payment (e.g., bundled service). This includes services performed as pre-admission or preoperative procedures when occurring within three days of the inpatient admission. The three-day window payment will apply to diagnostic and nondiagnostic services clinically related to the reason for the member's inpatient admission regardless of whether the inpatient and outpatient diagnoses are identical. Hospitals (or wholly owned or wholly operated physician practices) are allowed to bill services separately from the inpatient admission if the outpatient services are unrelated to the inpatient admission.

C. Definitions

- **Inpatient** – Member who is admitted to a hospital based upon the written orders of a physician or dentist and whose inpatient stay continues beyond midnight of the day of admission.
- **Outpatient Services** – Diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a physician or dentist which are furnished to an outpatient by a hospital. Outpatient services do not include direct-care services provided by physicians, podiatrists, and dentists.
- **Inpatient Services** – All covered services provided to members during the course of an inpatient hospital stay except for direct-care services provided by physicians, podiatrists, and dentists. Emergency room (ER) services are covered as an inpatient service when member is admitted from the ER.

D. Policy

I. Three-Day Payment Rule.

   A. Claims submitted for outpatient services, including emergency room and observation services, provided within the three calendar days prior to the inpatient admission for the same member for the same hospital may be denied, because the inpatient and outpatient services must be combined when they are related.

      1. The outpatient services and inpatient admission must be submitted on one inpatient claim.
      2. The dates of the claims should begin with the outpatient service through the inpatient discharge.

   B. If the hospital submits the outpatient claim separately before the inpatient claim, the inpatient claim may be deemed as a duplicate claim and may be denied payment. The hospital will need to void the paid claim for the outpatient service

Archived

and resubmit the inpatient claim so that it includes inpatient and outpatient services.

C. Physician practices and entities should use modifier PD (diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days or 1 day) to identify services subject to the payment window.

D. It is recommended that ICD-10 diagnosis code Z01.81X be used to indicate an encounter for preprocedural examinations to flag the outpatient claim as related to an inpatient service/procedure.

II. Outpatient hospital behavioral health services provided in the outpatient hospital setting within three calendar days prior to the inpatient admission are exempt from the three-day window policy.

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	08/17/2022	
Date Revised		
Date Effective	01/01/2023	
Date Archived	07/31/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References
1. Centers for Medicare & Medicaid Services (CMS). (2021 December 1). Three Day Payment Window – Implementation of New Statutory Provision pertaining to Medicare 3-Day (1-Day) Payment Window Policy – Outpatient Services Treated As Inpatient. Retrieved August 1, 2022 from www.cms.gov.
2. Centers for Medicare & Medicaid Services (CMS). (2020 December 3). FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients. MLN Matters SE20024. Retrieved August 12, 2022 from www.cms.gov.
3. Centers for Medicare & Medicaid Services (CMS). (2012 June 14). Frequently Asked Questions CR 7502. Retrieved August 1, 2022 from www.cms.gov.
4. Centers for Medicare & Medicaid Services (CMS). (2011, December 21). Pub 100-04 Medicare Claims Processing, Transmittal 2373. Retrieved July 29, 2022 from www.cms.gov.

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

Archived