CareSource

ADMINISTRATIVE POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Three-Day Window Payment-MP-AD-1227	GA, IN, KY, WV: 08/01/2023-07/31/2024 OH: 09/01/2023-07/31/2024

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.

This policy applies to the following Marketplace(s):				
☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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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
I. State-Specific Information....4

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 for acute care and treatment.
- **Inpatient Services** – Care and treatment provided to a member during a hospital admission. Emergency room (ER) services are covered as an inpatient service when member is admitted from the ER.
- **Outpatient Services** – Health care services furnished by or under the direction of the Provider.

D. Policy

I. Three-Day Payment Rule

A. Claims submitted for a member's outpatient services (including emergency room and observation services) that are provided within three calendar days prior to the inpatient admission at the same hospital or wholly owned hospital system may be denied, because related inpatient and outpatient services must be combined.

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, then the inpatient claim may be deemed duplicative and payment may be denied. The hospital will need to void the paid claim for the outpatient service and resubmit the inpatient claim so that it includes inpatient and outpatient services.

C. If both the outpatient and inpatient services are initially paid for the same hospital or wholly owned hospital system, retroactive recovery may be initiated for the outpatient services inclusive by the three-day window.

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D. 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 three days or one day) to identify services subject to the payment window.
E. ICD-10 diagnosis code *Z01.81X* should 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 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	05/10/2023	Annual review: updated policy process to reflect retroactive recovery, updated references and definitions
Date Effective	GA, IN, KY, WV: 08/01/2023 OH: 09/01/2023	
Date Archived	GA, IN, KY, WV:07/31/2024 OH: 07/31/2024	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. Three Day Payment Window – Implementation of New Statutory Provision pertaining to Medicare 3-Day (1-Day) Payment Window Policy – Outpatient Services Treated As Inpatient. December 1, 2021. Accessed April 21, 2023. www.cms.gov.
2. Centers for Medicare & Medicaid Services. FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients. MLN Matters SE20024. December 3, 2020. Accessed April 21, 2023. www.cms.gov.
3. Centers for Medicare & Medicaid Services. Frequently Asked Questions CR 7502. June 14, 2012. Accessed August 1, 2022. www.cms.gov.

Archived

4. Centers for Medicare & Medicaid Services. Pub 100-04 Medicare Claims Processing, Transmittal 2373. Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Practices. December 21, 2011. Accessed April 21, 2023. www.cms.gov.

5. State-Specific Information

A. Georgia
Effective: 08/01/2023

B. Indiana
Effective: 08/01/2023

C. Kentucky
Effective: 08/01/2023

D. Ohio
Effective: 09/01/2023

E. West Virginia
Effective: 08/01/2023

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