ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Three-Day Window Payment-GA MCD-AD-0999	08/01/2022-10/31/2023
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.

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A. Subject

Three-Day Window Payment

B. Background

Services provided within three days of an inpatient admission or discharge for the same or a related diagnosis is considered part of the admission.

C. Definitions

- **Inpatient** - A member who has been admitted to a participating hospital on recommendation of a licensed doctor and is receiving room, board, and professional services in the hospital on a continuous twenty-four hour a day basis. A length of stay less than twenty-four hours may be considered inpatient if the service can only be provided on an inpatient basis. Transfers between units within the hospital are not considered new admissions.
- **Outpatient Services** - A member who is receiving professional services at a participating hospital.
- **Same or Related Diagnosis** - Primary diagnosis code based on the first three digits of the ICD-10 code.

D. Policy

I. Three-Day Payment Rule

A. Claims submitted for outpatient services (including laboratory and radiology services) that were provided within the three calendar days prior to the inpatient admission for the same member will be denied because the inpatient and outpatient services must be combined.

1. This only applies when:
   a. The same or related diagnosis are considered part of the inpatient admission; and
   b. Services are provided by the same facility.

B. The outpatient services and inpatient services must be submitted on one inpatient claim.

C. The dates of the claim should be inclusive of the outpatient and inpatient services.

D. If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim will be denied with EOB 6516 – *Outpatient services performed three days prior to inpatient admission.* To resolve this denial, providers should void the outpatient claim in history, incorporate the outpatient services into the inpatient claim, and resubmit the corrected inpatient claim.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

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G. Review/Revision History

DATES		ACTION
Date Issued	04/29/2020	
Date Revised	01/15/2021 02/04/2022	Changed from PY and resources Annual review. Editorial changes
Date Effective	08/01/2022	
Date Archived	10/31/2023	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. Georgia Department of Community Health Division of Medicaid. (2022, January 1). *PART II Policies and Procedures for Hospital Services.* Retrieved February 10, 2022 from www.mmis.georgia.gov.

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