REIMBURSEMENT POLICY STATEMENT
GEORGIA MEDICAID

Policy Name		Policy Number	Effective Date
Three-Day Payment Window		PY-1043	09/01/2020-07/31/2022
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management 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 federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy 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.

CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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

Three-Day Payment Window

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Services provided within 3 days of an inpatient admission or discharge for the same or related diagnosis provided by the same facility are 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 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

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

E. Related Policies/Rules

F. Review/Revision History

	DATE	ACTION
Date Issued	04/29/2020	
Date Revised		
Date Effective	09/01/2020	
Date Archived	07/31/2022	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.

G. References

1. Georgia Department of Community Health Division of Medicaid. (2019, October). *PART II Policies and Procedures for Hospital Services.* Retrieved November 1, 2019 from www.mmis.georgia.gov

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

GA-MED-P-131362 Date Issued 04/29/2020 DCH Approved 06/09/2020