ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Three-Day Window Payment-OH MCD-AD-1001	09/01/2023
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
Three-day Window Payment

B. Background
The Ohio Administrative Code 5160-2-02(G) states that outpatient services provided within three calendar days prior to the date of admission in hospitals will be covered as inpatient services. This includes emergency room and observation services.

C. Definitions
- **Behavioral Health (BH) Services** – Include mental health and substance use disorder services. Hospitals that provide outpatient BH services must meet the Medicare conditions of participation, have accreditation by a national accrediting body, and have accreditation for the BH services that they provide.
- **Inpatient** – Member who is admitted to a hospital based upon the written orders of a practitioner of physician services and whose inpatient stay continues beyond midnight of the day of admission.
- **Inpatient Services** – Services which are ordinarily furnished in a hospital for the care and treatment of patients, including all covered services provided to members during the course of their inpatient hospital stay except for direct-care services provided by a practitioner of physician services. Emergency room (ER) services are covered as an inpatient service when member is admitted from the ER.
- **Outpatient Services** – Diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a practitioner of physician services which are furnished to an outpatient by a hospital. Outpatient services do not include direct-care services provided by a practitioner of physician services.
- **Practitioner of Physician Services** – Include physicians, podiatrists, dentists, clinical nurse specialists, certified nurse-midwives, certified nurse practitioners, or physician assistants.

D. Policy
I. Three-Day Payment Rule
A. Claims submitted for outpatient services (including emergency room and observation services) that were provided within the three calendar days prior to the inpatient admission for the same member for the same hospital or wholly owned hospital system may be denied if the services are not combined into one claim.
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 inpatient hospital will need to work with the outpatient hospital to pay the outpatient visit and to have the outpatient hospital void its paid claim for

the outpatient service. The inpatient hospital should then resubmit the claim so that it includes inpatient and outpatient services.

C. If both the inpatient and outpatient 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.
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.
F. To avoid duplication for nursing facility residents:
    1. The outpatient service claim should note the entire inpatient stay along with the dates of the outpatient services; and
    2. The nursing facility claim should note the room and board days with the hospital leave days.

II. The following exceptions apply:
    A. When a member's Medicaid coverage changes payer sources (fee-for-service or managed care) on the date of the inpatient admission, all outpatient services provided within three calendar days prior to the inpatient admission will be submitted to the payer source responsible for those dates of service. The inpatient claim will be submitted to the payer source in effect on the date of admission.
    B. When a member is admitted under the inpatient hospital service program benefit plan, all outpatient services provided by either the same hospital or different hospital, prior to the inpatient admission will not be included on the inpatient claim, with the exception of any outpatient services provided on the date of admission which will be included on the inpatient hospital claim if provided at the same facility as the inpatient admission.
    C. 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

	DATES	ACTION
Date Issued	10/30/2019	Changed from PY. Added to the same hospital in I.A.

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

Date Revised	02/04/2022 05/10/2023	Annual review. Editorial changes Annual review: added I.C, updated references, definitions. Approved at Committee.
Date Effective	09/01/2023	
Date Archived		

H. References

1. Ohio Department of Medicaid. Office of Policy: Hospital Billing Guidelines. Revised July 26, 2021. Accessed April 20, 2023. www.medicaid.ohio.gov.
2. General Provisions: Hospital Services, OHIO ADMIN. CODE 5160-2-02 (2022).