CareSource

ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Three-Day Window Payment-OH MCD-AD-1001	11/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements contain supplemental information regarding standard benefit administration and coverage details. Administrative Policy Statements do not guarantee an authorization or payment of services. The Member's plan contract (e.g., Evidence of Coverage, Member Handbook) contains specific terms and conditions, including limitations, exclusions, benefit maximums, eligibility, and other relevant conditions of coverage. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject
Three-Day Window Payment

B. Background
Ohio Administrative Code 5160-2-02 states that outpatient services provided within 3 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** – Services that 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 provided.
- **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** – Includes pharmacists, clinical psychologists, 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 3 calendar days prior to the inpatient admission for the same member for the same hospital may be denied if the services are not combined into 1 claim.
1. The outpatient services and inpatient admission must be submitted on 1 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 retroactive recovery may be initiated for the outpatient services inclusive by the 3-day window.
D. Physician practices and entities should use modifier *PD* (diagnostic or related non-diagnostic item or service provided in the same hospital to a patient who is admitted as an inpatient within 3 days or 1 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.
    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 3 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.

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.
Date Revised	02/04/2022 05/10/2023 01/17/2024	Annual review. Editorial changes Annual review: added I.C, updated references, definitions. Approved at Committee.

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

	05/07/2025 05/20/2026	Annual review: updated references. Approved at Committee. Review: updated references, approved at Committee Review: updated references, approved at Committee
Date Effective	11/01/2026	
Date Archived		

H. References

1. *Hospital Billing Guidelines*. Ohio Dept of Medicaid. Revised July 26, 2021. Accessed April 23, 2026. www.medicaid.ohio.gov
2. General Provisions: Hospital Services, OHIO ADMIN. CODE 5160-2-02 (2026).

Approved by ODM on 08/05/2026

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