



REIMBURSEMENT POLICY STATEMENT OHIO MEDICAID

Original Issue Date:		Next Annual Review		Effective Date	
01/01/2016		05/03/2018		01/01/2016	
Policy Name				Policy Number	
Three-Day Payment Window				PY-0128	
Policy Type					
Medical	Administrative	Pharmacy	REIMBURSEMENT		

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) 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.

CSMG Co. 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.

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A. SUBJECT

Three-Day Payment Window

B. BACKGROUND

- I. Medicare Background: Section 102 of the “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010,” Pub. L. 111-192, signed into law on June 25, 2010, sets forth, in part, the Medicare three-day payment window, which is Medicare's policy for payment of outpatient services provided on either the date of a beneficiary's admission or during the three calendar days immediately preceding the date of a beneficiary's inpatient admission to a “subsection (d) hospital” subject to the inpatient prospective payment system (IPPS). Under the Medicare three-day payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services that are furnished to the beneficiary during the 3-day payment window. Under the three-day payment window policy, all outpatient diagnostic services furnished to a Medicare beneficiary by a hospital (or an entity wholly owned or operated by the hospital), on the date of a beneficiary's admission or during the 3 days immediately preceding the date of a beneficiary's inpatient hospital admission, must be included on the Part A bill for the beneficiary's inpatient stay at the hospital. According to CMS, this law makes the policy pertaining to admission-related outpatient nondiagnostic services more consistent with common hospital billing practices.
- II. Ohio Medicaid Background: The Ohio Department of Medicaid amended the Ohio Administrative Code 5160-2-02 to adopt a similar three-day payment window for outpatient services rendered prior to an inpatient admission occurring on and after January 1, 2016. Specifically, the amended section 5160-2-02(B)(2) states: “Effective for inpatient admissions that begin on or after January 1, 2016, outpatient services, as described in paragraph (B)(4) of this rule, provided within three calendar days prior to the date of admission in hospitals described in rule 5160-2-01 of the Administrative Code will be covered as inpatient services. This includes emergency room and observation services.” The OAC three-day payment window policy differs from the Medicare policy in that it requires that all outpatient diagnostic and non-diagnostic services rendered within the payment window be bundled with the inpatient claim, regardless of whether or not the services are clinically related to the admission.

C. DEFINITIONS

- For purposes of this policy, “Hospital” is defined as hospitals described in rule 5160-2-01 of the Ohio Administrative Code, and
- “Outpatient services” are defined at OAC Section 5160-2-02(B)(4) as follows: Diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a physician or dentist which are furnished to an outpatient by a hospital as defined in rule 5160-2-01 of the Administrative Code. Outpatient services do not include direct-care services provided by physicians, podiatrists and dentists. Outpatient services exclude direct-care physician services except as provided in rule 5160-4-01 of the Administrative Code.
- “Wholly owned” is defined as follows: An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. (See 42 CFR §412.2)
- “Wholly operated” is defined as follows: An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. (See 42 CFR §412.2)



D. POLICY

- I. General. As an Ohio Medicaid Managed Care Entity, it is the CareSource policy that effective for inpatient admissions that begin on or after January 1, 2016, outpatient services, as described in paragraph (B) (4) of OAC 5160-2-02(B) (2), provided within three calendar days prior to the date of admission in hospitals described in rule 5160-2-01 of the Ohio Administrative Code, will be covered as inpatient services. This includes emergency room and observation services. This rule applies to all outpatient services provided by the admitting hospital, as well as hospitals wholly owned or operated by the admitting hospital. Therefore, hospitals must bundle on the inpatient claim all outpatient services rendered by the admitting hospital or a hospital wholly owned or operated by the hospital within three (3) calendar days prior to the date of admission.
- II. Compliance with Three-Day Payment Rule.
 - A. Outpatient claims submitted by a Hospital and rendered on or after January 1, 2016 are subject to this rule and will be denied if rendered within three calendar days prior to an inpatient admission of the same patient receiving the outpatient services.
 1. Any previously paid outpatient claims, if subject to this rule, will be denied.
 2. Claims where a Hospital has been paid for an inpatient claim and subsequently submits a claim for an outpatient service that was rendered within three calendar days prior to the inpatient admission of that patient will be denied.
 - B. Examples:
 1. Patient A received an outpatient service from Hospital A on January 1, 2016. Hospital A submitted the claim as an outpatient claim. On January 4, 2016, Patient A is admitted to Hospital A as an inpatient. The outpatient service rendered to Patient A on January 1, 2016 will be denied and is subject to recoupment because it was rendered within three calendar days of Patient A's inpatient admission to Hospital A.
 2. Patient B received an outpatient service from Hospital B on January 1, 2016. On January 5, 2016, Patient B is admitted to Hospital B as an inpatient. The outpatient service rendered to Patient B on January 1, 2016 will be approved (provided that it otherwise meets any applicable service and reimbursement requirements) because it was rendered outside of the three-day payment window.

E. CONDITIONS OF COVERAGE

F. RELATED POLICIES/RULES

<https://www.caresource.com/documents/observation-care/>

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	01/01/2016	
Date Revised		
Date Effective	01/01/2016	



H. REFERENCES

1. 42 CFR 412.2(c)(5)
2. Medicare Claims Processing Manual (Pub. 100-4), Chapter 3, section 40.3, "Outpatient Services Treated as Inpatient Services."
3. OAC 5160-2-02(B)(2)

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

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