REIMBURSEMENT POLICY STATEMENT
OHIO MEDICARE

Original Issue Date	Next Annual Review	Effective Date
5/12/2017	05/01/2018	5/12/2017-06/30/2021
Policy Name		**Policy Number**
Three-Day Payment Window		PY-0142
Policy Type		
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) 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.

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Contents of Policy

A. SUBJECT

Three-Day Payment Window

B. BACKGROUND

General: Outpatient diagnostic services and certain outpatient non-diagnostic services provided to Medicare beneficiaries by a "subsection (d) hospital" subject to the inpatient prospective payment system (IPPS) (hospital), or an entity wholly owned or operated by a hospital, on either the date of a beneficiary's admission or during the three (3) calendar days immediately preceding the date of a beneficiary's inpatient admission to a hospital, are paid as part of the inpatient stay under the IPPS. This rule is generally known as the "three-day payment window policy". Under this rule, a hospital or its wholly owned/operated entity cannot bill Medicare separately for outpatient diagnostic and certain outpatient non-diagnostic services and must include them on the claim for the patient's inpatient stay. Historically, the three-day payment window policy applied automatically to all outpatient diagnostic services provided in the 3-day window and to those outpatient non-diagnostic services that shared the same diagnosis code as the inpatient admission.

Section 102 of the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010," Pub. L. 111-192 (PACMBPRA), signed into law on June 25, 2010, broadened and clarified the Medicare three-day payment window policy. Under the Medicare three-day payment window policy as broadened by PACMBPRA, 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 not only the diagnoses, procedures, and charges for all outpatient diagnostic services, and all non-diagnostic services that have the same diagnosis code as the inpatient admission, but also any non-diagnostic services that are "clinically--related" to the inpatient admission. Under the policy, all outpatient diagnostic and clinically-related non-diagnostic services furnished to a Medicare beneficiary by an IPPS 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.

Under the PACMBPRA, CMS presumes that all outpatient non-diagnostic services rendered in the 3-day window are clinically related to the inpatient admission unless the hospital attests that specific non-diagnostic services are unrelated to the inpatient hospital claim.

For non-IPPS hospitals and units -- including psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals – the pre-admission window is 1 day instead of 3 days.

CareSource, as a Medicare Advantage plan, follows the Medicare three-day payment window policy for IPPS hospitals, and the one-day payment window for non-IPPS hospitals, as expanded by PACMBPRA, for services rendered to CareSource Medicare Advantage beneficiaries.

C. DEFINITIONS

- For purposes of this policy, "hospital" is defined as an admitting hospital that is a "subsection (d) hospital" subject to the inpatient prospective payment system (IPPS), entities "wholly owned" or "wholly operated" by the admitting hospital, and entities under arrangements with the admitting hospital.
- "Non-IPPS Hospital" is an admitting hospital that is not paid under the Medicare hospital Inpatient Prospective Payment System, including psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals.

- "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)
- "Diagnostic services": According to CMS Internet Only Manual Publication 100-02, Chapter 6, Section 20.4.1, "[a] service is 'diagnostic' if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of a disease. Among these examinations and tests are diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests given to determine the nature and severity of an ailment or injury."

D. POLICY

I. General. As a Medicare Advantage plan, it is the CareSource policy that outpatient diagnostic services provided to a CareSource member by a hospital on the date of an inpatient admission or within 3 days (or 1 day for non-IPPS hospitals) prior to the date of the inpatient admission are deemed to be inpatient services and included in the inpatient payment. These services must be bundled on the hospital's claim for the inpatient stay. In addition to diagnostic services, non-diagnostic services provided by a hospital on the day of the inpatient admission or on any of the 3 days (or 1 day for a non-IPPS hospital) immediately prior to the date of the admission must also be bundled on the claim for the member's inpatient stay at the admitting hospital, unless the hospital attests that the non-diagnostic service or services are unrelated to the hospital inpatient stay.

II. Services subject to this rule:
   A. Diagnostic services
   B. Clinical lab services
   C. Non-diagnostic services furnished during the 3-day (or 1-day) payment window that have the same diagnosis code as the inpatient admission
   D. Non-diagnostic services furnished during the 3-day (or 1-day) payment window that are "clinically-related" to the inpatient admission

III. Compliance with Three-Day (and One-Day) Payment Rule.
   A. All outpatient claims submitted by a Hospital are subject to this rule and will be denied if rendered within three calendar days (or one calendar day for non-IPPS hospitals) 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 (or one calendar day for non-IPPS hospitals) prior to the inpatient admission of that patient will be denied.
      3. Related entities should add Modifier PD to claims for diagnostic and nondiagnostic services that are subject to the payment window rule.
      4. Hospitals are not required to bundle with the inpatient claim outpatient non-diagnostic services provided during the payment window that are not clinically related to the inpatient admission. A hospital must maintain documentation in the medical record to support its claim that the preadmission outpatient non-diagnostic services are not clinically related to the inpatient admission. Unrelated outpatient non-diagnostic

services must be billed separately from the hospital's claim for the inpatient admission as follows:

4.1 Examples:

a. 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.\

b. 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

G. REVIEW/REVISION HISTORY

	ACTION	
Date Issued	05/12/2017	
Date Revised		
Date Effective	05/12/2017	
Date Archived	06/30/2021	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. 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."

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