ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Three-Day Window Payment-GA MCD-AD-0999	09/01/2024
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
Services provided within 3 days of an inpatient admission or discharge for the same or a related diagnosis are considered part of the admission.

C. Definitions
- **Hospital** – An institution engaged in providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- **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 24 hour a day basis. A length of stay less than 24 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** – A member receiving professional services at a participating hospital.

D. Policy
I. Three-Day Payment Rule
A. Claims submitted for outpatient services, including laboratory & radiology services, provided within the 3 calendar days prior to the inpatient admission or discharge for the same member for the same hospital or wholly owned hospital system may be denied if the services are not combined into 1 claim. This only applies to the following conditions:
1. The same or related diagnosis is considered part of the inpatient admission.
2. Services are provided by the same hospital or an entity that it wholly owns or operates. If a third organization owns or operates both the hospital and the entity, then the 3-day payment rule does not apply.

B. The dates listed on the claim must be inclusive of the outpatient and inpatient services.

C. If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim may be deemed a duplicate claim and may be denied payment. 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.

D. 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 3-day window.

E. 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 3 days or 1 day) to identify services subject to the payment window.

F. 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.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

DATES		ACTION
Date Issued	04/29/2020	
Date Revised	01/15/2021 02/04/2022 05/10/2023 05/08/2024	Changed from PY and resources Annual review. Editorial changes Annual review: updated policy process to reflect retroactive recovery, updated references and definitions. Approved at Committee. Review: updated references, approved at Committee
Date Effective	09/01/2024	
Date Archived		

H. References

1. Definitions, GA. COMP. R. & REGS. 111-3-10-.01 (2024).
2. *Policies and Procedures for Hospital Services, Part II.* Georgia Dept of Community Health; 2024. Accessed April 12, 2024. www.mmis.georgia.gov