ADMINISTRATIVE POLICY STATEMENT
Indiana Medicaid

Policy Name & Number	Date Effective
Three-Day Window Payment-IN MCD-AD-1000	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
- **Inpatient Services** – Services provided while the member is registered as an inpatient in an acute care or psychiatric hospital.
- **Outpatient Services** – Services provided to a member who is registered with the facility but not registered as an inpatient.

D. Policy
I. Three-Day Payment Rule
A. Claims submitted for outpatient services that were provided within the 3 calendar days prior to the inpatient admission for the same member may be partially denied if the services are not combined into one claim.
1. This only applies when:
a. Outpatient services and inpatient admission occur at the same facility, and
b. The same or related diagnosis are considered part of the inpatient admission.
2. The outpatient services and inpatient admission must be submitted on 1 inpatient claim.
3. The dates of the claim should reflect the date of the earliest outpatient service billed not the date of admission.
B. If an outpatient claim is paid before the inpatient claim is submitted, the inpatient claim may be denied with Explanation of Benefit (EOB) 6516 – *Outpatient services performed three days prior to inpatient admission.* 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.
C. If an outpatient claim is submitted after the inpatient claim has been paid, the outpatient claim may be denied with an EOB indicating that the inpatient claim may be adjusted to reflect the outpatient services provided to the patient.
D. If both the inpatient and outpatient services are initially paid for the same facility, 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 member who is admitted as an inpatient within 3 days or 1 day) to identify services subject to the payment window.

II. This policy is not applicable when the outpatient and inpatient services are provided by different facilities. This policy is also not applicable when the inpatient stay is less than 24 hours. Outpatient services provided within 3 days preceding a less-than-24-hour inpatient stay are billed as an outpatient service.

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

DATES		ACTION
Date Issued	10/30/2019	
Date Revised	01/15/2021 02/04/2022 05/10/2023 05/08/2024	Changed from PY policy, Updated resources Annual review. Editorial changes Annual review. Updated retroactive review process and code recommendations, references, removed definition for same or related procedures. Approved at Committee Review: updated references, approved at Committee
Date Effective	09/01/2024	
Date Archived		

H. References

1. "Inpatient Services" Defined, 405 IND. ADMIN. CODE 5-2-12 (2023).
2. "Outpatient Services" Defined, 405 IND. ADMIN. CODE 5-2-19 (2023).
3. *Provider Reference Module Inpatient Hospital Services*. Indiana Family & Social Services Administration; 2023. (January 24, 2023). Accessed April 12, 2024. www.in.gov
4. *Provider Reference Module Outpatient Facility Services*. Indiana Family & Social Services Administration; 2022. Accessed April 12, 2024. www.in.gov

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