ADMINISTRATIVE POLICY STATEMENT
Michigan Medicaid

Policy Name & Number	Date Effective
Three-Day Payment Window-MI MCD-AD-1377	06/01/2024
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 Payment Window

B. Background

CareSource follows the three-day window payment policy as established by the Centers for Medicare & Medicaid Services (CMS). According to the three-day rule, if an admitting hospital (or wholly owned or wholly operated physician practice) provides diagnostic or nondiagnostic services 3 days prior to and including the date of the member's inpatient admission, the services are considered inpatient services and are included in the inpatient payment (eg, bundled service). This includes services performed as pre-admission or preoperative procedures when occurring within 3 days of the inpatient admission. The three-day window payment will apply to diagnostic and nondiagnostic services clinically related to the reason for the member's inpatient admission regardless of whether the inpatient and outpatient diagnoses are identical. Hospitals (or wholly owned or wholly operated physician practices) are allowed to bill services separately from the inpatient admission if the outpatient services are unrelated to the inpatient admission.

C. Definitions

- **Inpatient** – Member who has been formally admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. The decision to admit a patient is a complex medical judgement, which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.
- **Outpatient** – When members with known diagnoses enter a hospital for a specific, minor surgical procedure or other treatment that is expected to keep the member in the hospital for less than 48 hours, regardless of the hour the member came to the hospital, whether a bed was used, and whether the member remained in the hospital past midnight.

D. Policy

I. Three-Day Payment Rule

A. Claims submitted for a member's outpatient services, including emergency room and observation services, that are provided within 3 calendar days prior to the inpatient admission at the same hospital or wholly owned hospital system may be denied, because related inpatient and outpatient services must be combined.

1. The outpatient services and inpatient admission must be submitted on one 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, then the inpatient claim may be deemed duplicative and payment may be denied.

The hospital will need to void the paid claim for the outpatient service and resubmit the inpatient claim so that it includes inpatient and outpatient services.

C. If both the outpatient and inpatient 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 three-day window.
D. 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 three days or one 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.

II. Outpatient hospital behavioral health services provided within 3 calendar days prior to the inpatient admission are exempt from the three-day window policy.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	09/27/2023	New policy. Approved at Committee.
Date Revised	03/13/2024	Review: updated references. Approved at Committee.
Date Effective	06/01/2024	
Date Archived		

H. References

1. Centers for Medicare & Medicaid Services. Three Day Payment Window – Implementation of New Statutory Provision pertaining to Medicare 3-Day (1-Day) Payment Window Policy – Outpatient Services Treated as Inpatient. September 6, 2023. Accessed February 22, 2024. www.cms.gov
2. Centers for Medicare & Medicaid Services. FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later are Admitted as Inpatients. MLN Matters SE20024. December 3, 2020. Accessed February 22, 2024. www.cms.gov
3. Centers for Medicare & Medicaid Services. Frequently Asked Questions CR 7502. June 14, 2012. Accessed February 22, 2024. www.cms.gov
4. Centers for Medicare & Medicaid Services. Pub 100-04 Medicare Claims Processing: Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Practices. Transmittal 2373. December 21, 2011. Accessed February 22, 2024. www.cms.gov

5. *Medicaid Provider Manual*. Michigan Dept of Health and Human Services; 2023. Updated January 1, 2024. Accessed February 22, 2024. www.mdch.state.mi.us
6. *Provider Manual*. HAP Empowered; 2023. Accessed February 22, 2024. www.hap.org

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