Three-Day Payment Window

Reimbursement Policy ID: RPC.0091.0900

Recent review date: 08/2024

Next review date: 05/2026

AmeriHealth Caritas New Hampshire reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas New Hampshire may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses reimbursement of facility outpatient services provided during the 3-day (or 1-day) payment window of an inpatient admission.

Exceptions

This excludes ambulance and maintenance renal dialysis services within the 3-day time-period. If appropriate, condition code 51 (attestation of unrelated outpatient non-diagnostic services) may be used to separately bill outpatient non-diagnostic services.

Also excluded are Critical Access Hospitals (CAH) when Medicare is primary; services with a maternity diagnosis and partial hospitalization programs (PHP).

Reimbursement Guidelines

The 3-day payment window applies to hospitals reimbursed according to Medicare's Inpatient Prospective Payment System (IPPS), and the 1-day rule applies to non-IPPS hospitals, i.e., inpatient psychiatric facilities and units, inpatient rehabilitation hospitals and units, long-term care hospitals, cancer hospitals and children's hospitals. Under the 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 member'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 (or 1-day for a non-IPPS hospital) payment window prior to admission. For example, if a member is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, and Wednesday are bundled with the inpatient stay.

Any outpatient services billed with a date of service within the dates of an inpatient admission are not reimbursable.

Modifier PD identifies a 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. This modifier is used for billing outpatient professional services subject to the 3-day window.

Definitions

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Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI)

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
08/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by [Insert plan name] from Policy History section
01/2023	Template Revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section