Payment Policy: 3-Day Payment Window

Reference Number: LA.PP.500
Product Types: ALL
Effective Date: 08/2020 **Coding Implications**
Last Review Date: 08/2020 **Revision Log**

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview
Louisiana Healthcare Connections covers certain services, procedures or devices provided to members in accordance with the member's coverage documents, when rendered by participating providers and, in certain circumstances, by non-participating provides, all in accordance with the treating provider's scope of practice and this policy. While this policy serves as a guideline and general reference regarding reimbursement for the "3-day payment rule," it is not intended to address every reimbursement situation. In instances that are not specifically addressed by this policy or addressed by another policy or contract, we retain the right to use reasonable discretion in interpreting this policy and applying it (or not applying it) to the reimbursement of services provided to all or certain members.

Louisiana Healthcare Connections is adopting a reimbursement policy that is based, in large part, on the Medicare requirements for payment of outpatient diagnostic and related non-diagnostic services within the 3-day (or, with respect to non-IPPS hospitals [as defined below], the 1-day) window prior to and including the date of member's inpatient admission. 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. Medicare basically requires hospitals to bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g., therapeutic) with the claim for an inpatient stay when services are furnished to a patient within 3 days (or, with respect to non-IPPS hospitals, within 1 day), prior to and including the date of an inpatient admission in compliance with Section 1886 of the Social Security Act. For example, if a member is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, and Wednesday are bundled.

The purpose of this policy is to ensure that payment for the technical component of all outpatient diagnostic services and related non-diagnostic services are bundled with the claim for an inpatient stay when services are furnished within 3 calendar days (or, with respect to a non-IPPS hospital, within 1 day) prior to and including the date of the inpatient admission. The bundling requirement does not apply to those services excluded from time to time from this policy, such as, ambulance and outpatient maintenance renal dialysis services.

Application
The policy applies to payment for outpatient services rendered by the admitting hospital, by an entity "wholly owned" or "wholly operated" by the admitting hospital, or by another entity under arrangements with the admitting hospital, to Louisiana Healthcare Connections members prior to and including the date of an inpatient admission. The 3-day bundling requirement applies to

hospitals reimbursed according to Medicare's Inpatient Prospective Payment System (IPPS), and the 1-day bundling requirement rule applies to hospitals that are not reimbursed according to Medicare's IPPS (which include, as of the effective date, inpatient psychiatric facilities and units, inpatient rehabilitation hospitals and units, long-term care hospitals, cancer hospitals and children's hospitals). This policy applies to all hospitalizations that are paid using an all-inclusive payment methodology.

Policy Description

All hospitals (other than non-IPPS hospitals) are subject to a 3-day bundling requirement when they furnish preadmission diagnostic services to a member on the date of the inpatient admission or within the 3 calendar days prior to the date of the inpatient admission, or when they furnish preadmission non-diagnostic services that are related to the member's inpatient admission, on the date of the inpatient admission or within 3 calendar days prior to the date of the inpatient admission.

All non-IPPS hospitals are subject to the 1-day bundling requirement when they furnish preadmission diagnostic services to a member on the day of the inpatient admission or within the 1 calendar day prior to the date of the inpatient admission, or when they furnish preadmission non-diagnostic services that are related to the member's inpatient admission, on the date of the inpatient admission or within 1 calendar days prior to the date of the inpatient admission.

Reimbursement
Hospital Services
Outpatient diagnostic services (including clinical diagnostic laboratory tests) provided to a member by a hospital on the date of an inpatient admission or within 3 days (or with respect a non-IPPS hospital, 1 day) prior to the date of the inpatient admission are deemed to be inpatient services and included in the inpatient payment (e.g., per diem, DRG, or per-case payment). This provision does not apply to services excluded from time to time from this policy. As of the effective date, the following services are excluded from being subject to this bundling requirement: ambulance services, maintenance renal dialysis services, and services furnished by skilled nursing facilities, home health agencies, and hospices.

Outpatient diagnostic services provided to a member by a hospital on the date of an inpatient admission or within 3 days (or with respect a non-IPPS hospital, 1 day) prior to the date of the inpatient admission are deemed to be inpatient services and must be bundled on the admitting hospital's claim for the member's inpatient stay at the admitting hospital.

Outpatient diagnostic services include, but are not limited to, the following revenue and/or CPT codes:

Code	Description
0254	Drugs incident to other diagnostic services
0255	Drugs incident to radiology

0341, 0343	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals
0371	Anesthesia incident to Radiology
0372	Anesthesia incident to other diagnostic services
0471	Audiology diagnostic
0481, 0489	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275, and G0278 diagnostic
0482	Cardiology, Stress Test
0483	Cardiology, Echocardiology
0918- 0919	Testing- Behavioral Health

Diagnostic services billed on outpatient bill types will be denied when the line-item date of service (LIDOS) falls on the day of admission or any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission.

In addition to diagnostic services; non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by a hospital on the day of the inpatient admission or on any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission and that are deemed related to the admission, are considered inpatient services, and must be bundled on the claim for the member's inpatient stay at the admitting hospital, unless the hospital attests (as provided below) to specific non-diagnostic services as being unrelated to the hospital inpatient stay (i.e., the preadmission non-diagnostic services must be clinically distinct or independent from the reason for the member's admission).

When outpatient diagnostic services and related non-diagnostic services must be bundled on the admitting hospital's claim for the member's inpatient stay at the admitting hospital, the admitting hospital must convert CPT codes to ICD-9-CM procedure codes and must only include outpatient diagnostic and admission-related non-diagnostic services that are included within the applicable payment window.

Outpatient non-diagnostic services provided during the payment window that are unrelated to the admission may be separately billed. A hospital must maintain documentation in the member's medical record to support its claim that the preadmission outpatient non-diagnostic services are unrelated to the inpatient admission. For such unrelated outpatient non-diagnostic services, the hospital must bill the unrelated outpatient non-diagnostic services separately from the admitting hospital's claim for the inpatient admission and must include on the claim a condition code 51 (Attestation of Unrelated Outpatient Non-diagnostic Services) for the separately billed outpatient non-diagnostic services.

Outpatient facility claims for non-diagnostic services will be denied when the following occurs:

(1) condition code 51 (Attestation of Unrelated Outpatient Non-diagnostic Services) is not included on the outpatient claim for non-diagnostic services provided during the payment window that are unrelated to the admission; and

(2) the line-item date of service (LIDOS) falls on the day of admission or any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission.

Professional Services
When a related facility furnishes a service subject to the provisions of this policy and submits a claim in accordance with this policy (e.g., the PD modifier described below is appropriately included), the following will be paid:

(1) the professional component for such a service with a technical and professional component split, or

(2) the facility rate for such a service that does not have a technical and professional component split.

Once the related entity has received confirmation of a member's inpatient admission from the admitting hospital, the related entity must append a CMS payment modifier to all claim lines for diagnostic services and for non-diagnostic services that have been identified as related to the inpatient stay that are furnished on the date of admission or within any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission.

Physician non-diagnostic services that are unrelated to the hospital admission are not subject to the payment window and should be billed without the payment modifier.

The payment 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), must be appended to the claim submitted by a related entity that is a physician practice/office for preadmission diagnostic and admission-related non-diagnostic services that are billed with HCPCS/CPT codes and that are subject to the provisions of this policy. The related entity must manage its billing processes to ensure that the claims for physician services are appropriately submitted when a related inpatient admission has occurred. The admitting hospital is responsible for notifying the related entity of an inpatient admission for a member who received services from a related entity within any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the inpatient admission.

Only unrelated non-diagnostic preadmission services are not subject to the above bundling and billing requirements. To be "unrelated," the preadmission non-diagnostic services must be clinically distinct or independent from the reason for the member's inpatient admission and must be furnished within any of the 3 days (or with respect to a non-IPPS hospital, the 1 day) immediately prior to the date of the admission. Note: non-diagnostic services furnished by a related entity that is a physician practice/office on the date of a member's inpatient admission to

the admitting hospital are always deemed to be related to the admission and the technical portion for such services must be included on the bill for the inpatient admission.

Documentation Requirements
Admitting hospitals must include condition code 51 on the UB-04 when applicable, and related facilities are required to place modifier PD on diagnostic and related non-diagnostic items and services that are subject to the 3-day (1-day) payment window policy. Omission of the PD modifier will be regarded as an attestation that the services were not subject to the 3-day (1-day) payment window.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Condition Code	Descriptor
Condition Code 51	Attestation of Unrelated Outpatient Non-diagnostic Services. This condition code is for use on outpatient facility claims.

Modifier	Descriptor
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 This modifier is for use in billing outpatient professional services subject to the 3-day window.

Definitions
Admitting Hospital – the hospital at which inpatient admission occurs

Hospital – collectively, the admitting hospital, entities "wholly owned" or "wholly operated" by the admitting hospital, and entities under arrangements with the admitting hospital

Non-IPPS Hospital – an admitting hospital that is not paid under the Medicare hospital Inpatient Prospective Payment System

Related Facility – an entity that is "wholly owned" or "wholly operated" by the admitting hospital, or an entity under arrangement with the admitting hospital.

Wholly Operated – an entity for which 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.

Wholly Owned – an entity that for which a hospital is the sole owner of the entity. See 42 CFR §412.2.

Related Policies
Not Applicable

Related Documents or Resources
Not Applicable

References

1. *Current Procedural Terminology (CPT®)*, 2018
2. *HCPCS Level II*, 2018
3. *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM), 2018
4. *ICD-10-CM Official Draft Code Set*, 2018
5. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 3, Section 40.3 (Outpatient Services Treated as Inpatient Services)
6. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 90.7 (Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (including Physician Practices and Clinics): 3-Day Payment Window)
7. CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 90.7.1 (Payment Methodology: 3-Day Payment Window in Wholly Owned or Wholly Operated Entities [including Physician Practices and Clinics])
8. MLN Matters, MM7502 (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 Offices). Available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7502.pdf
9. MLN Matters, SE1232 (Frequently Asked Questions (FAQs) on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients). Available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1232.pdf

Revision History	
08/15/2020	Converted corporate to local policy.

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable LHCC administrative policies and procedures.

This clinical policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. LHCC retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom LHCC has no control or right of control. Providers are not agents or employees of LHCC.

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to an actual signature on paper.

Senior Director of Network Accounts: _____Electronic Signature on File_