Payment Policy: ~~3-Day Payment Wind~~24 Hour Payment Rule~~ow~~

Reference Number: LA.PP.500c
Product Types: ALL
Effective Date: ~~08/2020~~ 05/2023 **Coding Implications**
Last Review Date: ~~08/2020~~ 05/2023 **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 ~~member~~member/enrollees in accordance with the ~~member~~member/enrollee'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 twenty-four hour payment rule, ~~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 ~~member~~member/enrollees.

~~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~~member/~~enrollee~~'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~~member/~~enrollee~~ 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 ~~member~~members/enrollees 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 twenty-four hours~~3-day~~ bundling requirement when they furnish preadmission diagnostic services to a ~~member~~ on the date of the inpatient admission or within the ~~3~~twenty-four hour-s~~calendar days~~ prior to the date of the inpatient admission, or when they furnish preadmission non-diagnostic services that are related to the ~~member~~member's/enrollee's inpatient admission, on the date of the inpatient admission or within twenty-four hours~~3 calendar days~~ prior to the date of the inpatient admission.

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

NOTE: The information in this policy may not reflect all Provider's Contract.

Reimbursement
Hospital Services
Outpatient hospital services are defined as diagnostic and therapeutic services rendered under the direction of a physician or dentist to an outpatient in an enrolled, licensed and certified hospital. The hospital must also be Medicare certified. Covered outpatient hospital services provided to Medicaid beneficiaries are reimbursable.

Inpatient services shall not be billed as outpatient, even if the stay is less than 24 hours. Federal regulations are specific in regard to the definition of both inpatient and outpatient services. Billing outpatient services for a beneficiary who is admitted as an inpatient within 24 hours of the performance of the outpatient service is not allowed and the facility may be subjected to financial sanctions.

Outpatient services (including diagnostic testing) when the diagnosis code is similar/related to the diagnosis code on an inpatient admission and are performed either during or within 24 hours of the inpatient admission, regardless of hospital ownership, will not be reimbursed separately as an outpatient service. The inpatient hospital is responsible for reimbursing the hospital providing the outpatient services. The inpatient hospital may reflect the outpatient charges on its claim.

Exceptions to this criterion is:

- Outpatient therapy services performed within 24 hours before an inpatient admission or 24 hours after the beneficiary's discharge that are either related or unrelated to the inpatient stay; and 2.
- Transfers from a hospital emergency department to a different hospital/provider for inpatient admission

If one of the above exceptions are met, separate billing and payment for the outpatient hospital service are allowed

If a beneficiary is treated in the emergency room and requires surgery, which cannot be performed for several hours because arrangements need to be made, the services may be billed as outpatient provided that the beneficiary is not admitted as an inpatient.

Physicians responsible for a beneficiary's care at the hospital are responsible for deciding whether the beneficiary should be admitted as an inpatient. Physicians should use a 24 hour period as a benchmark, i.e., they should order admission for beneficiaries who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment, which can be made only after the physician has considered a number of factors. Admissions of particular beneficiaries are not covered or non-covered solely on the basis of the length of time the beneficiary actually spends in the hospital.

Medicaid will reimburse up to 48 medically necessary hours for a beneficiary to be in an outpatient status. This time frame is for the physician to observe the beneficiary and to determine the need for further treatment, admission to an inpatient status or for discharge. If the beneficiary is admitted as an inpatient, the admit date will go back to the beginning of the outpatient services.

NOTE: Outpatient ambulatory surgery and other applicable revenue codes associated with the surgery may now be billed as outpatient regardless of the duration of the outpatient stay.

Outpatient diagnostic services (including clinical diagnostic laboratory tests) provided to a ~~member~~member/enrollee by a hospital on the date of an inpatient admission or within twenty-four hours~~3 days~~ (or with respect a non-IPPS hospital, twenty-four hours~~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~~member/enrollee by a hospital on the date of an inpatient admission or within twenty-four hours~~3 days~~ (or with respect a non-IPPS hospital, twenty-four hours~~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~~member's/enrollee'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 twenty-four hours~~3 days~~ (or with respect to a non-IPPS hospital, the twenty-four hours~~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 twenty-four hours~~3 days~~ (or with respect to a non-IPPS hospital, the twenty-four hours~~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~~member's/enrollee'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~~member's/enrollee's admission).

When outpatient diagnostic services and related non-diagnostic services must be bundled on the admitting hospital's claim for the ~~member~~member's/enrollee'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~~member's/enrollee'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~~twenty-four hours (or with respect to a non-IPPS hospital, the ~~1 day~~twenty-four hours) 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~~member's/enrollee'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 twenty-four hour~~3 dayss~~ (or with respect to a non-IPPS hospital, the twenty-four hour~~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 twenty-four hours~~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~~member/enrollee who received services from a related entity within any of the ~~3 days~~twenty-four hours (or with respect to a non-IPPS hospital, the ~~1 day~~twenty-four hour) 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~~member's/enrollee's inpatient admission and must be furnished within any of the ~~3 days~~twenty-four hours (or with respect to a non-IPPS hospital, the ~~1 day~~twenty-four hour) 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~~member's/enrollee'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~~2022, 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.

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®)*, 2022~~18~~
2. *HCPCS Level II*, 20~~18~~22
3. *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM), 2022~~18~~
4. *ICD-10-CM Official Draft Code Set*, 2022~~18~~
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	Revision Date	Approval Date
Converted corporate to local policy.	08/15/2020	
~~Updated~~Revised policy to follow State guidelines for 24 hour payment~~.~~ Changed policy name from 3 Day Payment Window to 24 Hour Payment Rule to be in line with state guidelines.	5/2023	

Important Reminder
This payment~~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~~ payment 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 payment~~clinical~~ policy. This payment~~clinical~~ policy is consistent with standards of medical practice current at the time that this ~~clinical~~payment policy was approved.

The purpose of this payment~~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 ~~paymnt~~payment~~clinical~~ policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this payment~~clinical~~ policy. This payment~~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 ~~paymen~~payment~~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 payment~~clinical~~ policy, and additional payment~~clinical~~ policies may be developed and adopted as needed, at any time.

This payment~~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 ~~member~~member/enrollees. This payment~~clinical~~ policy is not intended to recommend treatment for ~~member~~member/enrollees.

~~Member~~Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this payment~~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.

This payment~~clinical~~ policy is the property of LHCC. Unauthorized copying, use, and distribution of this payment~~clinical~~ policy or any information contained herein are strictly prohibited. Providers, ~~member~~member/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, ~~member~~member/enrollees and their representatives agree to be bound by such terms and conditions by providing services to ~~member~~member/enrollees and/or submitting claims for payment for such services.

~~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_~~

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