Priority Health	BILLING POLICY No. 034
THREE-DAY WINDOW	
Date of origin: July 2024	**Review dates: 2/2025**

APPLIES TO
All products, in- or out-of-network

OVERVIEW
Priority Health follows nationally accepted industry standards and coding principles defined for bundling in accordance with state and federal regulations and provider contract language. Unless otherwise stated in the facility contract, our policy is to ensure accuracy in payment for services that occur within the three-day window of inpatient hospital admissions or one-day window for other defined facility admissions.

Priority Health reserves the right to request supporting documentation to validate services billed and to guarantee accurate claims processing and reimbursement.

DEFINITION
In alignment with Medicare, we won't separately reimburse facilities for the technical component of all outpatients diagnostic services and related non-diagnostic services (i.e., therapeutic) occurring within the three days (or, with respect to non- Inpatient Prospective Payment System (IPPS) hospitals, within one day) of the inpatient hospital admission. This includes days prior to and including the date of an inpatient admission in compliance with Section 1886 of the Social Security Act.

Facilities subject to the one-day window include inpatient psychiatric facilities, inpatient rehab facilities, long-term care hospitals, cancer facilities and children's hospitals. Facilities must be aligned to the facility taxonomy and/or NPI types for these facility types.

Certain services provided by facilities within the three-day/one-day window of admission are considered part of the diagnosis-related groups of procedures (DRG) and aren't reimbursed separately. Those services include:

- Outpatient services followed by admission before midnight of the following day are treated as inpatient services and part of DRG.
- Diagnostic services (including clinical diagnostic laboratory tests) and related non-diagnostic services provided by the admitting hospital or entity owned by hospital prior to admission are deemed inpatient services and included in DRG payment.
- Other preadmission services are considered part of DRG when related to the admission and provided within three days of admission (or within one day of an emergency room service).
- Emergency room services within 24 hours of admission are part of DRG.
- Technical component of non-diagnostic services furnished by a related entity that's a physician practice/office on the date of a member's inpatient admission are always deemed to be related to the admission.

Learn more: Find information on DRGs and outlier payments in our Provider Manual.

POLICY SPECIFIC INFORMATION
CPT/HCPCS code descriptor
Below are the revenue codes which would likely be billed for the diagnostic tests as described in the Definition section of this policy. They represent the technical component of all outpatient diagnostic services and related non-diagnostic services (i.e., therapeutic) occurring within the three days (or, with respect to non-IPPS hospitals, within one day) of the inpatient hospital admission. This includes days

prior to and including the date of an inpatient admission in compliance with Section 1886 of the Social Security Act

- 0254: Drugs incident to other diagnostic services
- 0255: Drugs incident to radiology
- 0341: Nuclear medicine, diagnostic
- 0343: Nuclear medicine, 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, G0278 diagnostic
- 0482: Cardiology, Stress Test
- 0483: Cardiology, Echocardiology
- 0918, 0919: Testing- Behavioral Health

Services that may be excluded from bundling:

- Ambulance
- Outpatient maintenance renal dialysis services
- Diagnostic services rendered during ER visits 48 to 72 hours prior to admission are considered part of ER visit and are excluded from DRG payment, within a **Critical Access Hospital (CAH) only**.
- Services furnished by skilled nursing facilities, home health agencies and hospices
- Unrelated non-diagnostic preadmission services

Unrelated non-diagnostic preadmission services are excluded from bundling when accurately reported. Condition code 51 should be utilized for outpatient facility services to indicate services unrelated to admission.

- Condition Code 51: Attestation of unrelated outpatient non-diagnostic services. This condition code is for use on outpatient facility claims.
- To be “unrelated,” the preadmission nondiagnostic services must be clinically distinct or independent from the reason for the member’s inpatient admission and supported as such within the medical record.

Professional services

Related entities providing professional services for preadmission diagnostic and/or admission related non-diagnostic services report the appropriate CPT/HCPCS code along with the PD modifier.

- PD modifier: 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
- It’s the related entity’s responsibility to accurately manage and submit claims for related services when an inpatient admission has occurred
- It’s the facility’s responsibility to notify related entities of admissions for services provided within the three-day/one-day period

Claims accurately reported with the PD modifier will be reimbursed for the professional component when applicable for both a technical and professional component split. Services that don’t have a technical and professional split will be reimbursed at the facility rate.

Omission of the PD modifier or reporting of condition code 51 is an attestation that reported services were unrelated to the inpatient admission and must be supported by documentation as unrelated. Failure to accurately code or report these services as supported in the medical record may result in claim denials or recoupment through post payment audits.

REFERENCES

- CMS Publication 100-04, Medicare Claims Processing Manual
  - Chapter 3, Section 40.3
  - Chapter 12, Section 90.7 and 90.7.1
  - Chapter 12, Section 90.7.1
- 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)
- MLN Matters, SE1232 (Frequently Asked Questions (FAQs) on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 13, 2025	Added "Disclaimer" section