“Payment Policies assist in administering payment for UCare benefits under UCare’s health benefit plans. Payment Policies are intended to serve only as a general reference resource regarding UCare’s administration of health benefits and are not intended to address all issues related to payment for health care services provided to UCare members. In particular, when submitting claims, all providers must first identify member eligibility, federal and state legislation or regulatory guidance regarding claims submission, UCare provider participation agreement contract terms, and the member-specific Evidence of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, UCare also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®), InterQual guidelines, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT or other sources in UCare Payment Policies are for definitional purposes only and do not imply any right to payment. Other UCare Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other than as described by UCare Payment Policies when necessitated by operational considerations. “
PAYMENT POLICY OVERVIEW

PRODUCT SUMMARY

The 3-Day and 1-Day Payment Window Policy is applicable to Medicare and dual eligible (Medicare and State Public Program) products where Medicare is primary.

PROVIDER SUMMARY

The 3-Day and 1-Day Payment Window Policy applies to:

- Physicians
- Advance Practice Providers
- Hospitals (inpatient and outpatient)

POLICY STATEMENT

The 3-day and 1-Day Payment Window Policy outlines the guidelines implemented by Medicare including definitions of wholly owned and wholly operated, and accountability for determining when services are included or excluded from inpatient bundling and related payment guidelines.

PATIENT ELIGIBILITY CRITERIA

Any UCare Enrollee eligible for coverage.

DEFINITIONS

<table>
<thead>
<tr>
<th>TERM</th>
<th>NARRATIVE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wholly Owned</td>
<td>An entity is owned by the hospital and the hospital is the sole owner of the entity.</td>
</tr>
<tr>
<td>Wholly Operated</td>
<td>An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and the overseeing the entity’s routine operations, regardless of whether the hospital also has policymaking authority over the entity.</td>
</tr>
<tr>
<td>3-Day Payment Window</td>
<td>The 3-day Payment Window applies to services provided on the date of admission and the three (3) calendar days immediately preceding the date of admission.</td>
</tr>
<tr>
<td>1-Day Payment Window</td>
<td>The 1-day Payment Window applies to services provided on the date of admission and the one (1) calendar day immediately preceding the date of admission.</td>
</tr>
<tr>
<td>Outpatient Non-Diagnostic Services</td>
<td>The statutory change to the payment window policy significantly broadens the definition of non-diagnostic services to include non-diagnostic services (other than</td>
</tr>
</tbody>
</table>
DEFINITIONS

<table>
<thead>
<tr>
<th>TERM</th>
<th>NARRATIVE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ambulance and maintenance renal dialysis services</td>
<td>ambulance and maintenance renal dialysis services that are related to the hospital admission. This includes the technical portion of any admission related services provided by the hospital and any wholly owned or wholly operated physician clinic or other Part B entity. The primary diagnosis codes of the hospital and the wholly owned or wholly operated entity do not need to be the same.</td>
</tr>
</tbody>
</table>

Outpatient Non-Diagnostic Services

The statutory change to the payment window policy significantly broadens the definition of non-diagnostic services to include non-diagnostic services (other than ambulance and maintenance renal dialysis services) that are related to the hospital admission. This includes the technical portion of any admission related services provided by the hospital and any wholly owned or wholly operated physician clinic or other Part B entity. The primary diagnosis codes of the hospital and the wholly owned or wholly operated entity do not need to be the same.

Admission Related

As it relates to outpatient non-diagnostic/therapeutic services, admission related services are defined as those services clinically related to the admission regardless of whether the primary diagnosis codes are the same for the services provided by the hospital and the wholly owned or wholly operated entity.

PAYMENT AND BILLING INFORMATION

When a –PD modifier (Diagnostic or related non-diagnostic item or service provided in wholly owned or wholly operated entity to a patient who is later admitted as an inpatient within 3 days) is appended to a CPT or HCPCS code payment will be reduced. Payment guidelines are:

- Services with a Professional and Technical component (PC/TC split); only the professional component of the service(s) should be billed. When the service(s) provided have a PC/TC component (e.g., radiological services) both the -26 (professional component) and –PD modifier should be appended to the applicable service(s). The allowed amount for the professional component will be paid to the provider.
- Services without a PC/TC split – the allowed amount will be based on the facility based RVU/ facility based fee schedule.
- Global Surgical Services - Timeframes associated with 10 and 90 day global surgical packages could overlap with the 3-day or 1-day payment window policy. The 3-day payment window makes no change in billing surgical services according to global surgical coding guidelines, and pre- and post-operative services continue to be included in the payment for the surgery. However, there may be times when the surgery itself is subject to the 3-day payment window policy. For example, a patient could have a minor surgery in a wholly owned or wholly operated entity and then due to complications be admitted as an inpatient.
• The following Section of the Medicare Policy Manuals will provide additional information regarding the expected adjudication of the payment window Policy:


• The hospital that has ownership or complete operating responsibility must make the decision as to whether non-diagnostic services are clinically related or unrelated to a hospital admission. Once the hospital makes this determination, the Part B claim must be submitted consistent with the decision made by the hospital.

• When it is determined that services are clinically related the –PD modifier (Diagnostic or related non-diagnostic item or service provided in wholly owned or wholly operated entity to a patient who is later admitted as an inpatient within 3-days or 1-day) must be appended to the HCPCs/CPT when billing Medicare for Part B/professional services.

  • The physician’s office or other Part B Entity does not need to reduce their charges when appending the –PD modifier.
  • The –PD modifier may be appended with dates of service on or after January 1, 2012, but must be included for eligible services no later than July 1, 2012.

• If non-diagnostic services are unrelated to the inpatient hospital claims and are therefore clinically distinct from the reason for the Enrollee’s inpatient hospital admission, the technical portion of the claim should be included on the professional claim or the outpatient hospital claim. When this situation arises:

  • Condition code 51 (Attestation of an Unrelated Outpatient Non-Diagnostic Service) should be used by the hospital when they bill separately for unrelated outpatient non-diagnostic service claims.

The physician clinic or other Part B entity should not append the –PD modifier to the unrelated services. The absence of the-PD modifier would serve as the attestation that the hospital believes that the non-diagnostic service was unrelated to the hospital inpatient admission.
<table>
<thead>
<tr>
<th>MODIFIERS</th>
<th>NARRATIVE DESCRIPTION</th>
<th>GENERAL INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>-PD</td>
<td>Diagnostic or related non-diagnostic item or service provided in wholly owned or wholly operated entity to a patient who is later admitted as an inpatient within 3 days</td>
<td>For use on a professional claim. When the hospital determines that diagnostic and/or non-diagnostic services are admission related, the wholly owned or wholly operated physician clinic or other Part B entity will append the –PD modifier to indicate the services are related.</td>
</tr>
<tr>
<td>-26</td>
<td>Professional Component</td>
<td>For use on a professional claim. When the hospital determines that diagnostic and/or non-diagnostic services are admission related, and the wholly owned or wholly operated physician clinic or other Part B entity is billing for services that have a professional and technical split (e.g., radiology) only the professional component of the service should be billed. Both the -26 and –PD modifier should be appended to the claim.</td>
</tr>
</tbody>
</table>

### Referral or Condition Codes

<table>
<thead>
<tr>
<th>Referral or Condition Code</th>
<th>Description</th>
<th>Narrative Description</th>
<th>Direction / Explanation for Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Condition Code</td>
<td>-51</td>
<td>Attestation of an Unrelated Outpatient Non-Diagnostic Service</td>
<td>For use on a hospital claim. Appended when billing separately for unrelated outpatient non-diagnostic services.</td>
</tr>
</tbody>
</table>
## Prior Authorization or Threshold Limits

Not Applicable

## Related Payment Policy Documentation

**References to Other Payment Policy Documentation that May Be Relevant to This Policy.**

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Description and Link</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

## References and Source Documents

**Links to CMS, MHP, Minnesota Statute and Other Relevant Documents Used to Create This Policy.**

- **CMS Q&A**
  - [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/CR7502-FAQ.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/CR7502-FAQ.pdf)
- **CMS Manual**
- **Other Sources of Documentation**
  - [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/JSMTDL-10382-ATTACHMENT.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/JSMTDL-10382-ATTACHMENT.pdf)
- **CMS Memorandum Notice**
  - [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/JSMTDL-10382-ATTACHMENT.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/JSMTDL-10382-ATTACHMENT.pdf)
- **Comprehensive FAQ Published by CMS**