

Reimbursement Policy

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| Title: Same Day Same Service-ER to Inpatient/Observation | |
| Policy Number: RP12 | Applies to: <input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Level Funded <input checked="" type="checkbox"/> Medicare Advantage <input checked="" type="checkbox"/> Medicaid <input checked="" type="checkbox"/> Medicare Select <input checked="" type="checkbox"/> Medicare Supplement |
| Effective Date : 8/2026 | |
| Last Updated: * | |

Disclaimer

These coding and reimbursement policies serve as a guide to assist providers in accurate claims submissions and to outline the basis for reimbursement. The determination that a service, procedure, item, etc., is covered under a member's benefit plan is not a determination that the provider will be reimbursed. Services and items must also meet Quartz provider and billing guidelines appropriate to the procedure and diagnosis.

Providers must follow proper billing and submission guidelines, including the use of industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the clinical documentation.

Quartz coding and reimbursement policies apply to both participating and non-participating providers and facilities unless a specific exception is stated in the policy.

If proper coding/billing guidelines or current reimbursement policies are not followed, Quartz may:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

Quartz utilizes claim editing software to assess coding and billing accuracy on claims.

From time to time, Quartz may, in its sole discretion, revise these policies. When there is an update, Quartz will publish the most current policy to Quartz's Provider Manual.

Definitions

Same Day/Same Service: Same Physician or Other Qualified Health Care Professional: Physician(s) and/or Other Qualified Health Care Professional(s) of the same group and same specialty on the same calendar day.

Policy

Quartz will follow Medicare's 3-day or 1-day payment window rules. Outpatient services (including ER visits) that occur within 3 calendar days (72 hours) preceding an inpatient/observation admission at the same hospital system are generally considered part of the inpatient claim and should not be billed separately, unless deemed unrelated.

You may only bill one of the hospital inpatient or observation care codes per calendar date for initial and/or subsequent visit per day which follows both CPT guidelines and CMS. With the exception when the physicians are each responsible for a different aspect of the patient's care,

pay both visits if the physicians are in different specialties and the visits are billed with different diagnoses.

- Facility Billing (UB-04): The hospital should not submit a separate outpatient claim for the ED visit. Instead, all services provided in the ED on the date of admission must be included on the UB-04 inpatient claim
- Physician/Professional Billing (CMS-1500): According to CMS/Medicare policy, the physician should not bill both an ED visit and an initial hospital care code (99221-99223) on the same day. The surgeon/physician should report only the initial hospital care code (99221-99223), which represents the work for both the ED evaluation and the admission.

When two Emergency Room visits are performed on the same day by the same group for the same diagnoses, only one E/M should be billed. If the ED visit is completely unrelated to the admission, a modifier 25 may be used on the professional claim.

Related Policies

None

Resources

[Three Day Payment Window | CMS](#)

[r11842cp.pdf](#)

[Medicare Claims Processing Manual](#)

Compliance

Quartz conducts post-payment reviews and audits to ensure policy compliance. Misuse of codes, modifiers, or exceeding service limits may lead to provider education, recoupment, or other corrective action. Providers must submit supporting documentation, if requested, as part of claim review processes.

Document History

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| 4/22/2026 | Document created | Payment Integrity Department |
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