Reimbursement Policy

Title: Outpatient Services within 3 Days of Inpatient Admission	
Policy Number: RP19	**Applies to:** ☒ Commercial ☒ Level Funded ☒ Medicare Advantage ☒ Medicaid ☒ Medicare Select ☒ Medicare Supplement
Effective Date: 11/1/2026	
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

3 Day Rule: A policy that addresses the billing and reimbursement of outpatient hospital services rendered 3 days preceding an inpatient admission.

Policy

Quartz Medicare Advantage and Commercial plans follow Medicare's 3-Day Window Rule. Reimbursement is based on CMS guidance as follows:

For admitting hospitals, preadmission services are included in the inpatient reimbursement for the three (3) days prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses.

Note: This includes any entity wholly owned or wholly operated by the admitting hospital or by another entity under arrangements with the admitting hospital.

For the following other hospitals and units, preadmission services are included in the inpatient reimbursement within one (1) day prior to and including the day of the member's admission and, therefore, are not separately reimbursable expenses:

- Psychiatric hospitals and units
- Inpatient rehabilitation facilities and units
- Long-term care hospitals
- Children's hospitals
- Cancer hospitals

Critical Access Hospitals (CAH), preadmission services are not subject to either the three (3) day or one (1) day payment window and, therefore, are separately reimbursable expenses from the inpatient stay reimbursement.

The three (3) day or one (1) day payment window does not apply to preadmission services included in the rural health clinic (RHC) or federally qualified health center (FQHC) all-inclusive rate.

Additionally, a hospital may attest to specific nondiagnostic services as being unrelated by adding a condition code 51 to the outpatient nondiagnostic service to be billed separately. These services may be separately reimbursed when coding supported by medical records indicates a separately identifiable condition.

Quartz Medicaid plans will continue to follow Forward Health's Overlapping Inpatient and Outpatient Services and Continuous Stay guidance. Please note that reference laboratory services are not subject to the Overlapping Inpatient and Outpatient Services guidance.

Related Policies

Resources

CMS- Three Day Payment Window | CMS

ForwardHealth- Topic #8278 Continuous Stay Policy Print

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

9/1/2026	Document created	Payment Integrity Department