

### Medical Three-Day Payment Window

Important changes to Medicare claims processing instructions were effective **June 25, 2010**, with additional guidance issued in the FY11 IPPS final rule posted **July 30, 2010**. Claims processing instructions have been outlined to be effective **April 4, 2011**.

Medicare patients often receive outpatient services in the same facility prior to being admitted as an inpatient. These outpatient services can be either diagnostic or non-diagnostic (therapeutic) in nature. All short-term inpatient acute care facilities reimbursed under the Medicare Inpatient Prospective Payment System (IPPS) are subject to the 3-day payment rule; with a 1-day window for facilities exempt from IPPS (such as LTCH, inpatient rehab, inpatient psych). Critical access hospitals, on the other hand, are not subject to either 1-or-3-day payment windows.


Under this policy, when outpatient services are provided by the hospital (or an entity wholly owned or operated by the hospital) within the 3-day payment window, diagnostic services are included on the inpatient claim. Non-diagnostic (therapeutic) services are included on the inpatient claim if they are provided on the day of admission or are **clinically associated** with the reason for the patient’s inpatient admission.

### The “Three-Day” Window Applied to Diagnostic Services

Diagnostic outpatient services provided to a patient by the admitting hospital within 3 calendar days prior to and including the date of the inpatient admission are deemed to be inpatient services and will be included in the inpatient MS-DRG payment, unless there is no Part A coverage.

#### Example 1: Diagnostic Services Prior to Inpatient Admission

Patient is admitted as an inpatient on a Thursday. Diagnostic services that were provided by the hospital on Monday, Tuesday, Wednesday or Thursday are included in the inpatient Part A payment, and should be reported on the inpatient claim regardless of whether clinically associated with the reason for inpatient admission. *This provision does not apply to ambulance services and maintenance renal dialysis services.*

Monday	Tuesday	Wednesday	Thursday
<b>Lab</b> <i>Diagnostic service –                      Routine lab work.</i>		<b>X-ray</b> <i>Diagnostic service -                      patient falls; possible head                      injury. X-ray is negative</i>	 <b>Inpatient Admission</b> <i>For Stroke                      MS-DRG 66 Stroke</i>

**Report all diagnostic services on inpatient admission claim.**



**Example 2: Diagnostic Services Prior to Inpatient Admission**

Patient is admitted as an inpatient on a Thursday. Diagnostic services that were provided by the hospital on Monday, Tuesday, Wednesday or Thursday are included in the inpatient Part A payment and should be reported on the inpatient claim. *This provision does not apply to ambulance services and maintenance renal dialysis services.*

Monday	Tuesday	Wednesday	➡	Thursday
<b>Lab</b>	<b>Outpatient Surgery</b>			<b>Inpatient Admission</b>
<i>Diagnostic service – Preoperative blood work For Tuesday's surgery</i>	<i>Diagnostic service - Left heart catheterization Discharged Home</i>			<i>For Appendicitis MS-DRG 340 Appendectomy</i>

**Report all diagnostic services on inpatient admission claim.**

**Diagnostic services are defined by the presence of the following revenue code and/or CPT codes on the claim:**

- 0254 Drugs incident to other diagnostic services
- 0255 Drugs incident to radiology
- 030X Laboratory
- 031X Laboratory pathological
- 032X Radiology diagnostic
- 0341 Nuclear medicine, diagnostic
- 035X Computerized Axial Tomography (CT) scan
- 0371 Anesthesia incident to radiology
- 0372 Anesthesia incident to other diagnostic services
- 040X Other imaging services
- 046X Pulmonary function
- 0471 Audiology diagnostic
- 048X Cardiology, with HCPCS codes 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544-93552, 93561 or 93562
- 053X Osteopathic services
- 061X Magnetic Resonance Imaging (MRI)
- 062X Medical/surgical supplies, incident to radiology or other diagnostic services
- 073X Electrocardiogram (ECG/EKG)
- 074X Electroencephalography (EEG)
- 092X Other diagnostic services

**All of the revenue codes listed above denote diagnostic services to be billed on the inpatient claim when performed within 3 days prior to the inpatient admission or the same day of the inpatient admission.**

**Claims Processing Instructions:** If a hospital believes that a non-diagnostic outpatient service is truly distinct from and unrelated to the inpatient stay, the hospital may separately bill for the service provided that it has documentation to support that



the service is unrelated to the admission, consistent with the new provision. Such separately billed service may be subject to subsequent review.

According to instructions released October 29, 2010 in MLN 7142, the hospital attests that the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission by adding a **condition code 51** to the separately billed outpatient non–diagnostic services claim. Providers may submit outpatient claims with condition code 51 starting April 1, 2011. Outpatient claims processed prior to April 4, 2011, but with dates of service on or after June 25, 2010 may need to be adjusted by the provider if they were rejected by Medicare. Such adjustments should be made after April 4, 2011.

CMS used a similar approach with same–day readmissions that are unrelated. In those cases, hospitals can place condition code (CC) B4 on the inpatient claim that contains an admission date equal to the prior admissions discharge date that would allow the second stay to be paid separately. If the condition code is not included on the claim for a same day readmission, edits bundle the claim for the second admission into the first one and Medicare will only pay for one inpatient discharge.

**References:**

Centers for Medicare and Medicaid Services (CMS) 2011 IPPS Final Rule  
Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Pub. L. 111–192)  
Claims Processing Manual, Chapter 3 Section 40.3  
MLN Matters MM7142



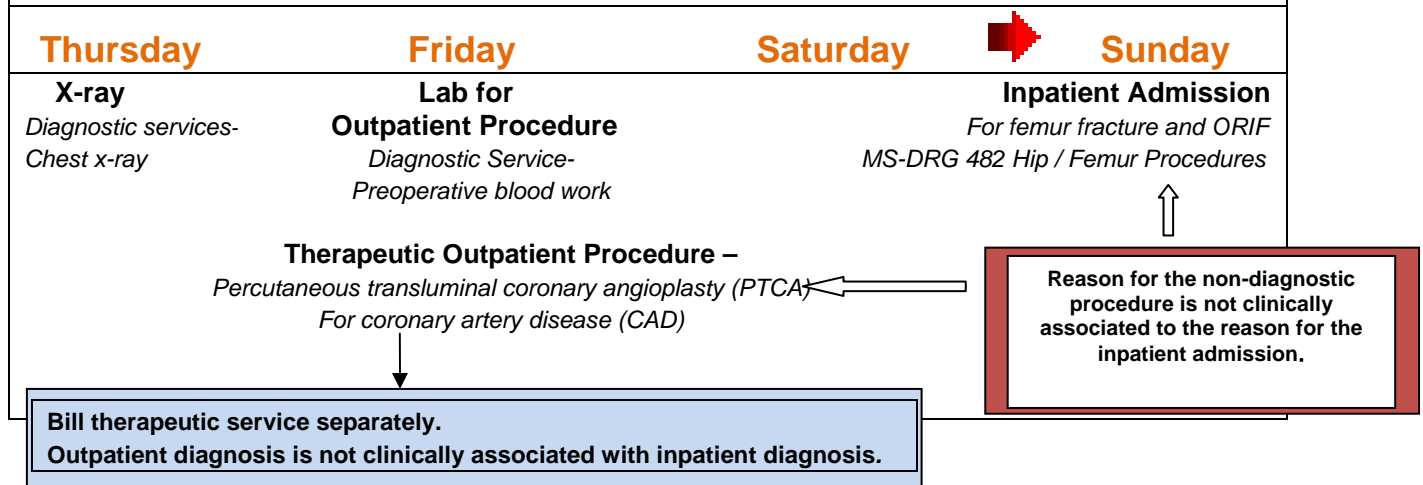
## Three-Day Window Applied to **Non-diagnostic (Therapeutic) Services**

Non-diagnostic (therapeutic) outpatient services provided to a patient by the admitting hospital on the date of the inpatient admission are deemed to be inpatient services. To appropriately apply the rule when therapeutic services are provided within the three days prior to admission, first determine if the outpatient services are related or not related to the inpatient admission. A non-diagnostic (therapeutic) service is related to the admission if it is **clinically associated** with the reason for a patient’s inpatient admission.

- When outpatient non-diagnostic (therapeutic) services, provided within the 3 days prior to admission are *not clinically associated* with the admission, they should be billed separately.
- When outpatient non-diagnostic (therapeutic) services, provided within the 3 days prior to admission *are clinically associated* with the reason for admission, the services should be reported on the inpatient claim.

### Example 3: Non-diagnostic (Therapeutic) Services

Non-diagnostic (therapeutic) services rendered 3 days prior to the date of admission that are not clinically associated with the admission may be separately reimbursed.



**Report only the diagnostic services (e.g., lab, x-ray) on inpatient claim. Therapeutic service (e.g., PTCA) is billed separately.**



**Example 4: Non-diagnostic (Therapeutic) Services**

Non-diagnostic (therapeutic) services rendered on the day of admission are included on the inpatient claim.

**Thursday AM**



**Thursday PM**

**Outpatient Surgery**

*Laparoscopic Cholecystectomy*

**Inpatient Admission**

*Exacerbation of COPD  
MS-DRG 988 Non-extensive OR Procedure  
Unrelated to the Principal Diagnosis*

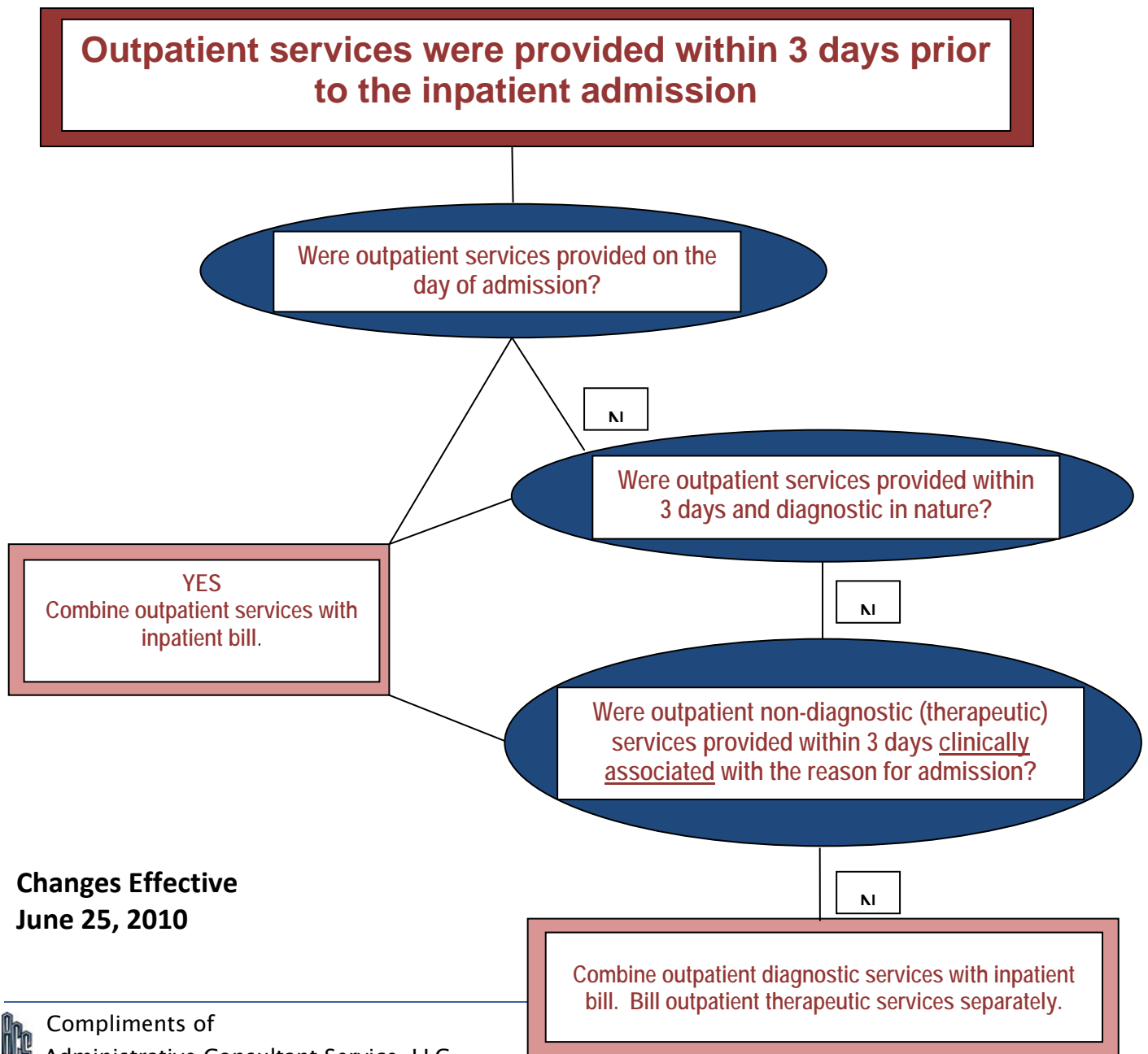
**Reason for the outpatient procedure may not be clinically associated, but was provided on the day of admission.**

*Outpatient therapeutic service (e.g., lap cholecystectomy) is included on the inpatient claim.*



### Three-Day Payment Window Decision Tree

For each inpatient claim, coding staff should review hospital admission data and ask the following to ensure the claim is billed correctly. Seek feedback from other staff, such as CDI nurses, case managers, etc. or consult the physician if it is unclear whether the reason for outpatient services is **clinically associated** with the reason for admission. *Note: an exact match of ICD-9-CM diagnosis codes is no longer required for conditions to be considered as related!*



**Changes Effective  
June 25, 2010**