The "Three-Day Window"

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 nondiagnostic (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. Nondiagnostic (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.

Hospitals are responsible for notifying a wholly owned / wholly operated entity of an inpatient admission of a Medicare beneficiary who received services in a wholly owned / wholly operated entity within the 3-day (or 1-day) payment window prior to the inpatient admission. The technical component of all diagnostic services and those direct expenses that otherwise would be paid through nonfacility practice expense relative value units for nondiagnostic services related to the inpatient admission are considered hospital costs and must be included on the hospital's bill for the inpatient stay. Medicare will pay the Physician Fee Schedule for the professional component for service codes with a Technical / Professional Component split, and at the facility rate for service codes without a TC/PC split. Physician practices or other Part B entities should use Modifier PD to identify HCPCS codes for services subject to the payment window. See CR 7502 for additional instruction.

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
Lab *Diagnostic service –* *Routine lab work.*		**X-ray** *Diagnostic service -* *patient falls; possible head injury. X-ray is negative*	**Inpatient Admission** *For Stroke* *MS-DRG 66 Stroke*

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
Lab *Diagnostic service –* *Preoperative blood work* *For Tuesday's surgery*	**Outpatient Surgery** *Diagnostic service -* *Left heart catheterization* *Discharged Home*		**Inpatient Admission** *For Appendicitis* *MS-DRG 340 Appendectomy*

Report all diagnostic services on inpatient admission claim.

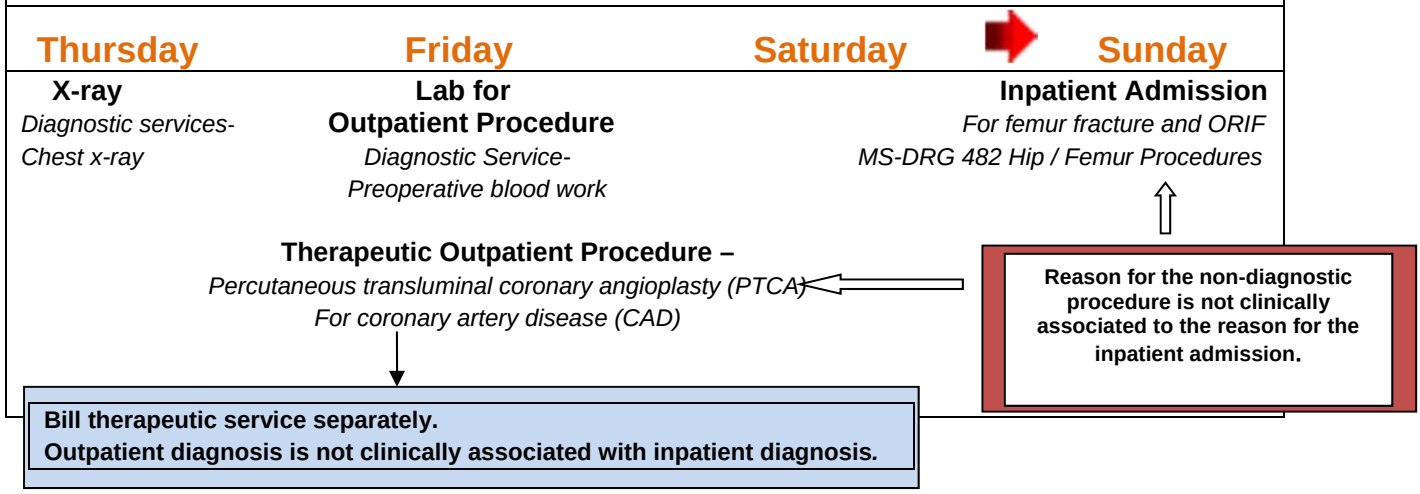
The "Three-Day" Window Applied to Therapeutic Services

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 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

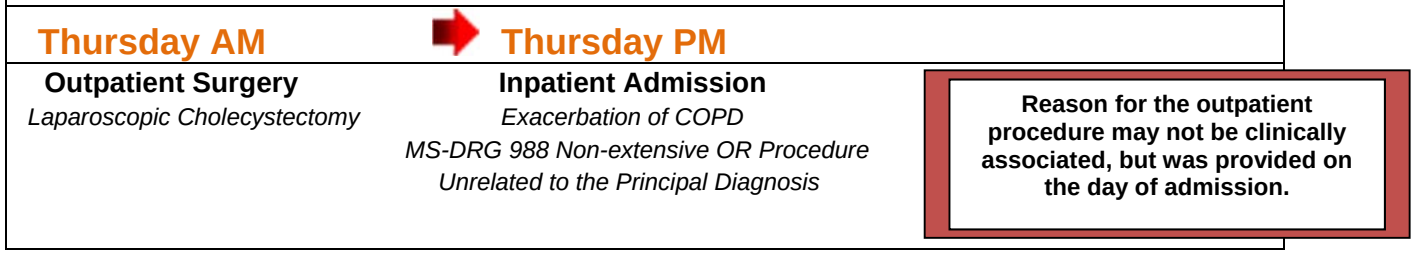
Non-diagnostic (therapeutic) services rendered 3 days prior to the date of admission that are not clinically associated with the admission may be separately reimbursed.



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.



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

<u>Claims Processing Instructions</u>: 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 CMS 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.

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.

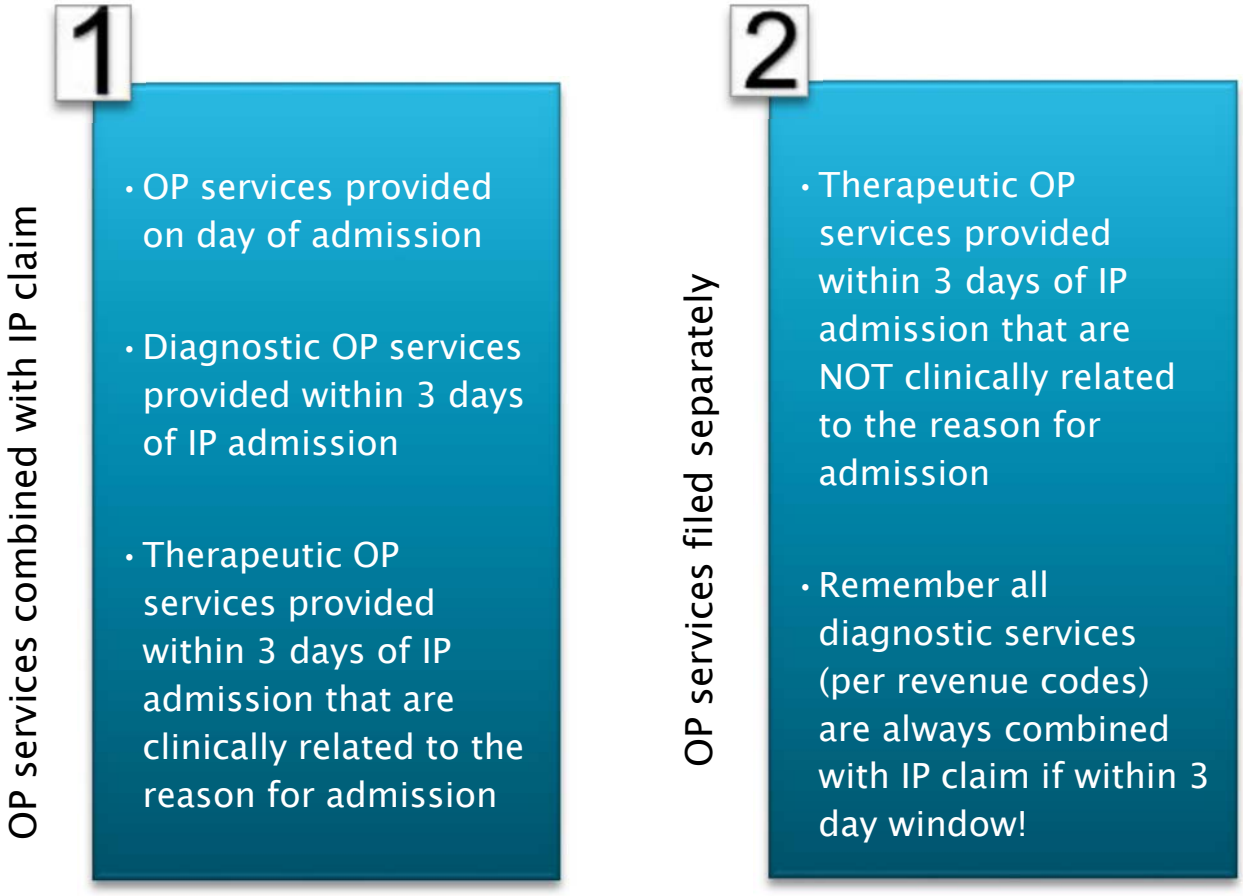
Diagnostic services revenue code and/or CPT codes on the claim:

- 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
- 0481, 0489 Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275, and G0278 diagnostic ***Includes cardiac catheterization – which can impact MS-DRG***
- 0482 Cardiology stress test
- 0483 Cardiology, echocardiology
- 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)
- 0918 Testing, behavioral health
- 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.

Three-Day Payment Window Decisions

For each inpatient claim, coding staff should review hospital admission data to ensure the claim is coded correctly. Seek feedback from other staff, such as CDI specialists, 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-10-CM diagnosis codes is no longer required for conditions to be considered as related!*



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; Chapter 12, Section 90.7
MLN Matters MM7142