Three-Day Window Updates

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The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 was signed into law on June 25, 2010. One of its provisions revised the three-day payment policy, or the so-called "three-day DRG window."

This article highlights the changes to the three-day window payment policy.

Three-Day Payment Window Background

Prior to June 25, 2010, hospitals were required to bundle all outpatient diagnostic services furnished to a Medicare patient on the date of a beneficiary's admission or during the three days preceding the inpatient hospital admission into the inpatient encounter.

On the other hand, outpatient nondiagnostic services provided during the payment window were to be included on the bill for the patient's inpatient stay at the hospital only when the services were "related" to the beneficiary's admission.

The term related was defined as an exact match of all five digits of the Medicare patient's diagnosis code in the outpatient encounter when compared to the inpatient hospital principal diagnosis code.

Three-Day Window Updates

Effective June 25, 2010, all short-term, inpatient acute care facilities reimbursed under the Medicare Inpatient Prospective Payment System (IPPS) are subject to the three-day payment rule. Those facilities exempt from the IPPS (e.g., long-term care hospitals, inpatient rehabilitation hospitals and units, facilities, psychiatric hospitals and units) are subject to a one-day window. Critical access hospitals are not subject to the one- or three-day payment window.

Under the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, when outpatient services are provided by the hospital (or an entity wholly owned or operated by the hospital) within the three-day payment window, diagnostic services are included on the inpatient claim. In other words, the new law made no changes to the Centers for Medicare and Medicaid Services' (CMS) long-standing policy regarding the billing of diagnostic services. These services are still required to be bundled into the DRG payment when performed within the payment window.

Take for example a patient who is admitted as an inpatient on a Thursday. The diagnostic services provided by the hospital on Monday, Tuesday, Wednesday, or Thursday should be reported on the inpatient claim.

CMS's Claims Processing Manual identifies diagnostic services by the presence on the bill of the revenue or CPT codes in the table at right.

The provision for nondiagnostic (therapeutic) services was revised under the new law. Nondiagnostic/therapeutic services are included on inpatient claims if they are provided on the day of admission or are clinically associated with the reason for the patient's inpatient admission and occur within the payment window.

Under the new statute the term "other services related to the admission" includes all outpatient services that are not diagnostic services (as defined by the table above and are not ambulance and maintenance renal dialysis services).

When a nondiagnostic/therapeutic service is provided to a Medicare patient by a hospital (or an entity wholly owned or wholly operated by the hospital), it will be bundled when the service occurs either on the date of the beneficiary's inpatient admission or during the three days (or in the case of a non-IPPS hospital, during the one day) immediately preceding the date of admission unless the hospital demonstrates (in a form and manner and at a time specified by the HHS secretary) that such services are not related (as determined by the HHS secretary) to such admission.

Revenue and CPT Codes That Identify Diagnostic Services

Diagnostic services are defined by the presence on the bill of the following revenue or CPT codes:

Revenue Code	Description
0254 -	Drugs incident to other diagnostic services
0255 -	Drugs incident to radiology
030X -	Laboratory
031X -	Laboratory pathological
032X -	Radiology diagnostic
0341, 0343 -	Nuclear medicine, diagnostic/diagnostic radiopharmaceuticals
035X -	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 93501, 93503, 93505, 93508, 93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561, or 93562 diagnostic

0482-	Cardiology, stress test
0483-	Cardiology, echocardiology
053X -	Osteopathic services
061X -	MRT
062X -	Medical/surgical supplies, incident to radiology or other diagnostic services
073X -	EKG/ECG
074X -	EEG
0918-	Testing-behavioral health
092X -	Other diagnostic services

FY2011 Hospital IPPS

The final rule for the FY 2011 hospital inpatient prospective payment system included the new three-day payment window rule. In the preamble, CMS stated that an outpatient service is "related" to an admission if it is "clinically associated with the reason for a patient's inpatient admission."

CMS is taking a broad view of what it means to be "clinically related" to an inpatient admission. The agency stated that, other than ambulance and maintenance renal dialysis services, all nondiagnostic services furnished by a hospital on the date of admission or during the three-day payment window are deemed to be related to the admission and, therefore, must be bundled with the inpatient stay.

The only exception to bundling outpatient nondiagnostic services into the inpatient claim is when a hospital determines and attests that the nondiagnostic outpatient service furnished during the three-day payment window is "clinically distinct or independent from the reason for the patient's admission." Hospitals must maintain documentation to support their assertion that a service is unrelated and submit an outpatient claim with a newly created condition code.

CMS adopted condition code 51, Attestation of unrelated outpatient nondiagnostic services, to identify outpatient services furnished during the three-day payment window that are not clinically associated with the inpatient admission. This means that the preadmission nondiagnostic services are clinically distinct or independent from the reason for the patient's admission.

In this instance, providers may submit an outpatient claim with condition code 51 to separately billed outpatient nondiagnostic services starting April 1, 2011.1 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 released a summary of the changes and instructions on the updates to the three-day payment policy to the provider community and to fiscal intermediaries and Medicare Administrative Contractors. The summary of the changes is available online at www.cms.gov/AcuteInpatientPPS/08a_Three_Day_Payment_Window.asp.

Examples of Nondiagnostic Outpatient Services and the Three-Day Window

Example 1: On Tuesday, a patient is treated in the emergency department for a cough and discharged home. On Thursday the patient is admitted for pneumonia. The nondiagnostic outpatient services provided to the patient in the ED three days prior to the inpatient admission would fall within the three-day payment window, as illustrated below.

Third day prior to admission	Second day prior to admission	First day prior to admission	Date of inpatient admit
Patient treated in the ED for cough and discharged home			Admitted for pneumonia
<-INSIDE the Payment Window->			

Example 2: A patient is admitted as an inpatient for a cataract extraction in the morning. In the evening, the patient is admitted due to chronic bronchitis. The nondiagnostic/therapeutic services provided to the patient on the day of the admission would be included on the inpatient claim based on the recently defined payment rules.

Note

1. Centers for Medicare and Medicaid Services. "Clarification of Payment Window for Outpatient Services Treated as Inpatient Services." MNL Matters Number MM7142. www.cms.gov/MLNMattersArticles/downloads/MM7142.pdf.

References

Centers for Medicare and Medicaid Services (CMS). "Clarification of Payment Window for Outpatient Services Treated as Inpatient Services." Transmittal 796. October 29, 2010. www.cms.gov/transmittals/downloads/R796OTN.pdf.

CMS. "Medicare Claims Processing Manual." Chapter 3, Inpatient Hospital Billing, Section 40.3. www.cms.gov/manuals/downloads/clm104c03.pdf.

CMS. "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services; Final Rule." *Federal Register* 75, no. 157 (August 16, 2010). http://edocket.access.gpo.gov/2010/pdf/2010-19092.pdf.

Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010. Pub. L. 111-192. www.govtrack.us/congress/bill.xpd?bill=h111-3962.

Coding and Reimbursement Resources

For more coding and reimbursement guidance, check out the following resources:

- *CodeWrite* e-newsletter, available in the AHIMA Body of Knowledge at www.ahima.org
- AHIMA's "Medical Coding" Web site at www.ahima.org/coding
- AHIMA's "Reimbursement Educational Resources and Products" Web site at www.ahima.org/resources/infocenter/reimbursement.aspx

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