

72-hour rule or 3-Day Payment Window. It doesn't matter what you call it, the mere mention of "it" strikes fear in the hearts of most reimbursement and coding managers. When do you combine outpatient accounts with inpatient accounts? What services can be combined? Diagnostic? Therapeutic? This whitepaper is designed to give you a clearer understanding of the 3-Day Payment Window—helping ensure that your hospital not only remains compliant, but also receives the Medicare payments it deserves – no more and no less.

## The 3-Day Payment Window

Getting It Right Means Getting Paid Properly  
And Remaining Compliant

HELPING HOSPITALS SURVIVE *and* THRIVE<sup>SM</sup>

When the 3-Day Payment Window first gained notice, hospitals were routinely returning overpayments to Medicare for billing outpatient encounters separately from inpatient encounters. Medicare had long required hospitals to combine the two – when services were provided within 3 days of each other – but it was a challenge to determine when outpatient and inpatient encounters overlapped within this window of time. Paying money back to the government certainly offered an incentive for them to figure it out.

If you are a critical access hospital (CAH), this provision does not apply to you. Because CAHs are exempt from the 1- and 3-day window provisions, services rendered by a CAH to a beneficiary who was an outpatient prior to being admitted as an inpatient are not bundled on the inpatient bill. Outpatient CAH services must be billed as such and on a separate bill (85x TOB) from inpatient services. Outpatient services rendered on the date of admission to an inpatient setting are still billed and paid separately as outpatient services in a CAH.

Today, most patient financial services (PFS) directors will tell you they “get it” – the need to combine any outpatient encounter within 3 days to the inpatient bill. But are they getting it right? Not exactly. Here’s why:

## DIAGNOSTIC SERVICES

According to the Medicare Hospital Manual, Chapter 3, Section 40.3, B. Preadmission Diagnostic Services, “Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary’s admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage.”

Okay, now in English: Combine any diagnostic services provided to an outpatient that occur within 3 days of an

inpatient admission. If you’re not sure what a diagnostic service is, Medicare gives you a list of revenue codes that must be combined.

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

## THERAPEUTIC SERVICES

What about therapeutic services – things like emergency visits, drug administration and surgical procedures? According to the manual, “Nondiagnostic outpatient services that are related to a patient’s hospital admission and that are provided by the hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the hospital), to the patient during the 3 days immediately

preceding and including the date of the patient's admission are deemed to be inpatient services and are included in the inpatient payment."

Sounds similar, right? Wrong. The important phrase here is "services that are related," which is explained as follows:

"Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay."

- This provision applies only when the patient has Part A coverage.
- This provision *does not* apply to ambulance services and maintenance renal dialysis.
- Additionally, Part A services furnished by skilled nursing facilities, home health agencies and hospices are excluded from the payment window provisions.

#### Example No. 1

An ER patient is seen with acute bronchitis (ICD-9-CM code 466.0). The patient goes home and returns 2 days later with pneumonia (ICD-9-CM code 486). Are the services related? No. Bill the therapeutic services for the ER visit separately as an outpatient, and combine only the diagnostic services on the inpatient bill.

Here is the UB-04 claim for the outpatient services.

**Remember, it is the revenue code that determines whether or not the service is diagnostic (combine) or nondiagnostic (bill separately on outpatient encounter).**

Revenue Code	Description	Combine?
250	Pharmacy	No
270	Supplies	No
300	Complete blood count	Yes
300	Basic metabolic panel	Yes
320	Chest x-ray	Yes
410	Respiratory Therapy	No
450	Emergency department visit	No
450	Intramuscular injection	No

#### Example No. 2

A patient has an outpatient cardiac cath for a diagnosis of coronary artery disease (ICD-9-CM code 414.01). The patient goes home and returns 2 days later for a coronary artery bypass graft with a diagnosis of coronary artery disease (ICD-9-CM code 414.01). Are the services related? Absolutely. Combine all of the charges on the outpatient claim with the charges on the inpatient claim.

#### Special Circumstances: Direct Admits

What about a patient who did not leave the hospital, but was directly admitted following an outpatient surgery due to a complication? According to *AHA Coding Clinic* (Third Quarter 2003, pages 10-11), Medicare's official source for coding guidelines, here's how the scenario should play out:

#### Question:

A patient is seen in the hospital outpatient surgery department for planned surgical repair of a unilateral inguinal hernia. The surgery was successfully performed and the patient recovers in the hospital's observation unit. During this recovery period, the patient has an acute myocardial infarction (AMI) of the anterior wall and is admitted as an inpatient to the same hospital. What is the principal diagnosis?

#### Answer:

Assign code 410.11, acute myocardial infarction of other anterior wall, initial episode of care, as the principal diagnosis. In this case, the patient had a documented condition, the AMI, which led to the inpatient admission. Therefore, the AMI would be the principal diagnosis. Code 550.91, inguinal hernia without mention of obstruction or gangrene, unilateral or unspecified (not specified as recurrent), should be assigned as an additional diagnosis. Assign code 53.00, unilateral repair of inguinal hernia, not otherwise specified, for the procedure performed.

This advice tells us to code the hernia repair on the inpatient account. However, the Medicare rules are clear and the accounts should not be combined.

The following has been reported by two Quality Improvement Organizations\*:

*“Although Coding Clinic would advise coders in certain circumstances to include services in coding that are completed prior to the admission, the Medicare 3-Day Payment Window provision stipulates that certain services would not be included, unless there is an exact match between the principal diagnosis code assigned for both the preadmission services and the inpatient stay. Remember, Coding Clinic provides coding advice. The “3-Day Payment Window” is a separate Medicare billing requirement that providers must follow in order to receive reimbursement.”*

Mutual of Omaha Medicare Provider Outreach and Education Advisory Group also notes “The 3-day provision applies even if there is no break in a stay between a Part B encounter and a Part A inpatient admission.”

\*Mountain Pacific Quality Health, the Medicare Quality Improvement Organization For Montana, Wyoming, Hawaii and Alaska

\*FMQAI, the Medicare Quality Improvement Organization for Florida

While considering the information above, also consider this payment comparison.

### Example No. 3

A patient had an outpatient laparoscopic cholecystectomy. Following the procedure, the patient began having difficulty breathing and was admitted with an acute exacerbation of chronic obstructive pulmonary disease (COPD).

**INCORRECT:** Combine the cholecystectomy with the inpatient encounter: DRG 988, DRG weight 1.8792 (using \$5,000 DRG rate) = \$9,396

**CORRECT:** Bill the cholecystectomy as an outpatient and the COPD exacerbation as an inpatient:  
DRG 192, DRG weight .7254 (using \$5,000 DRG rate) = \$3,627  
APC 131 = \$3,060  
Total payment = \$6,687

Part of the 3-Day Payment Window problem is that hospitals mistakenly believe they are accepting less payment by combining the outpatient services with the inpatient account. In Example No. 3, the hospital would have been overpaid \$2,709 by combining the two accounts and billing all of the services on the inpatient bill, but this isn't always the case.

## SUCCESSFULLY NAVIGATING THE 3-DAY PAYMENT WINDOW

- Don't believe the notion that you have to combine all outpatient services within 3 days to the inpatient account.
- Only combine services when the principal diagnosis on the outpatient encounter is identical to the principal diagnosis on the inpatient encounter.
- Use the action plan and decision tree below to establish policies and procedures that make the 3-Day Payment Window more clear and actionable.
- Review all DRG 468 (MS-DRGs 981 – 989) accounts to make sure you have coded them correctly.

## Action Plan 3-Day Payment Window

### Medical Record Review

- Pull a sample of claims and medical records that were combined due to the 3-Day Payment Window.
- Determine if the principal diagnosis on the outpatient record and the inpatient record were identical.
- If identical, determine if all services were combined to the inpatient account
- If not identical, determine if the diagnostic services were combined to the inpatient account (use diagnostic services section on page 2 to determine which revenue codes and charges should be combined) and if the therapeutic services were billed separately on an outpatient claim.

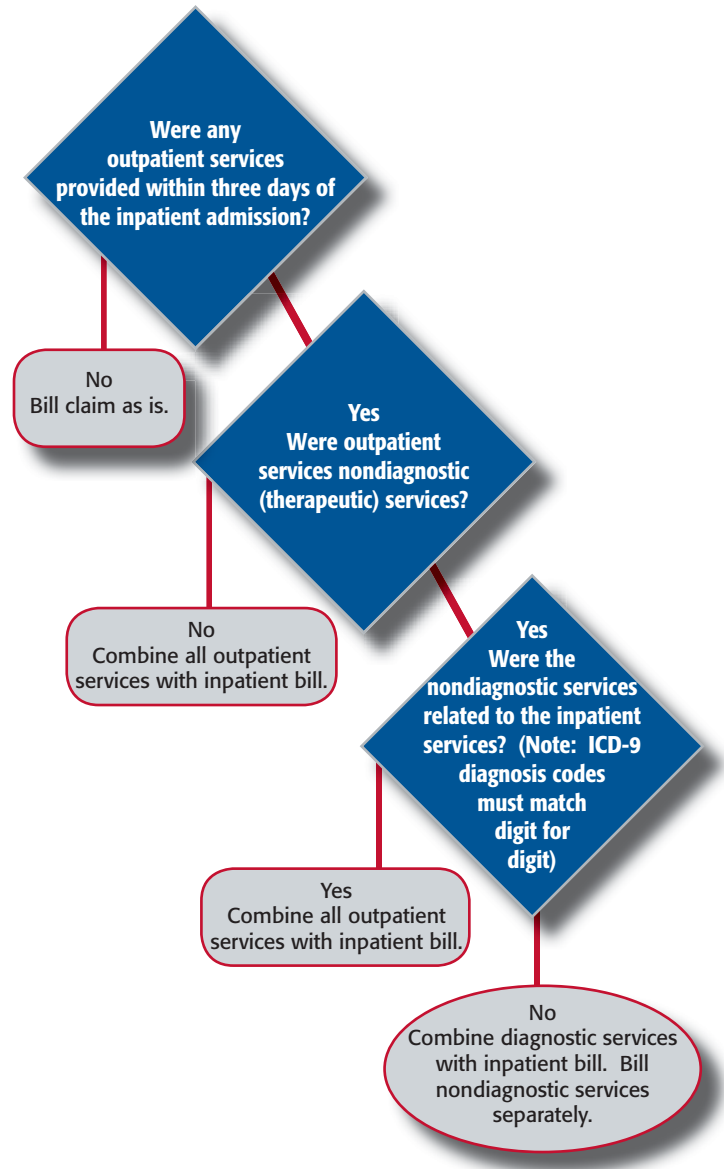
### Corrective Action

- If accounts were combined incorrectly, resubmit the claim.
- Improve billing processes to audit these accounts prior to initial bill submission.

### Resources

- Medicare Hospital Manual Chapter 3, section 40.3 B.

## 3-DAY DECISION TREE



## CONTACT INFORMATION



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