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Three-day window payment policy holds strong headed into ninth year

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Under Medicare rules for hospitals subject to the Inpatient Prospective Payment System (IPPS), when a patient received outpatient services in the three days before a related inpatient admission, payment for the outpatient services is bundled into the Diagnosis Related Group (DRG) payment for the stay. This rule, officially called the three-day payment window and sometimes referred to as the 72-hour rule, applies to diagnostic tests and other related services provided by the admitting hospital on the three calendar days prior to the patient's admission.

An example of this is a patient who receives pre-operative imaging or lab work before a scheduled surgery that requires an inpatient stay. If the patient is admitted on a Thursday, then services provided by the hospital on Monday, Tuesday, and Wednesday are included in the DRG payment. In addition to the admitting hospital, the policy also applies to entities wholly owned or operated by the hospital as well as entities providing these services under arrangements with the hospital.

The three-day window policy allows hospitals to remain neutral about whether pre-surgery work-up is done before or during the admission. The hospital can then make the decision based on what makes the most sense in the individual circumstances rather than on payment considerations.

The Policy History

Several state Medicaid agencies include this policy as part of their inpatient payment methodology, which is why it is important to stay up-to-date. The Centers for Medicare and Medicaid Services (CMS) finalized the three-day window policy January 1, 2012 under section 102 of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) (Pub. L. 111-192).

While finalized in 2012, the policy has a much longer history. CMS has long had an administrative policy requiring related outpatient services provided on the same day as an inpatient admission to be billed as inpatient services. This policy was first expanded in 1990 through the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990, Pub. L. 101-508). This legislation created the three-day window policy for hospitals paid under Medicare IPPS (the window remained one day for non-IPPS hospitals).

Exceptions

There are some exceptions to Medicare's policy. Critical Access Hospitals (CAH) are exempt from the payment window except when the outpatient diagnostic services are rendered to a patient by a CAH that is wholly owned or operated by a non-CAH hospital. The policy also does not apply if the hospital and other entities are both owned by a third party, such as a health system, or if the hospital is not the sole or 100 percent owner of the other entity.

Clinically unrelated services are not subject to the three-day window policy if the hospital can attest that the services are distinct or independent from a patient's admission. Ambulance services and maintenance renal dialysis services are also excluded.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) are not subject to the three-day window since these are paid under a separate payment method. A similar one-day window exists for psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals.

Outpatient services that are potentially subject to the three-day window are required to be submitted with modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity). If modifier PD is applied, only the professional component of a code (with both a professional and technical component provided) will be reimbursed by Medicare. The technical component is reimbursed on the inpatient claim. Condition code 51 (attestation of unrelated outpatient nondiagnostic services) should be used to identify services unrelated to the inpatient admission and be billed as outpatient services.

CMS provides a list of revenue and procedure code combinations that are subject to the payment window in the Medicare Claims Processing Manual.

Diagnostic Services Subject to the Three-Day Window Policy	
Rev. Code	Description
0254	Drugs incident to radiology
0255	Laboratory
030X	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 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275, and G0278 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 Other diagnostic services
092X	Other diagnostic services

Note:
1: Source - Medicare Claims Processing Manual, Chapter 3, Section 40.3B

Streamlining Payment Policies

As mentioned, many state Medicaid agencies follow Medicare's three-day window policy or have adopted similar policies based on Medicare's model. Such efforts reduce the administrative burden on hospitals of having to keep track of two separate windowing policies.

According to the Medicaid and CHIP Payment and Access Commission, 35 state Medicaid agencies have some sort of outpatient window payment policy. While many of these programs have adopted policies similar to Medicare, some differences remain as such.

Florida, for example, includes payment for observation in the 48 hours preceding an admission in the inpatient claim. In Illinois, hospitals have the option to bill one outpatient claim for emergency room or observation services, while all other ancillary services must be included on the inpatient claim. In addition, one salaried physician's services may also be billed under the physician's name and NPI.

While outpatient window policies can be tailored to state-specific objectives, the overarching goals remain consistent: payments for outpatient services directly related to an inpatient admission are included in the inpatient payment. Providers are accustomed to this policy because diagnostic testing performed in advance is often the primary reason for an inpatient admission. State Medicaid agencies who already use the three-day window policy should continue to rely on this payment policy. As always, it is advisable to keep up with any rule changes from Medicare.

The Payment Method Development team at Conduent advises states on how to adopt outpatient window policies, which affect both inpatient and outpatient billing practices, payment methods and Medicaid Management Information Systems. For further information, contact Andrew Townsend at Andrew.townsend@conduent.com.

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