Clarifications to CMS' Longstanding Three-day Rule

The Centers for Medicare & Medicaid Services' (CMS') three-day rule, also known as the 72-hour rule, has remained unchanged since its implementation in 1998. Despite its longevity, new questions have been raised regarding non-diagnostic outpatient services and the three-day rule. Specifically, hospitals are unclear whether non-diagnostic services rendered during the three-day payment window that are unrelated to a inpatient admission should be billed separately under Medicare Part B. In response to their concerns, CMS held a Hospital Open Door Forum on March 4. The forum provided clarifications to the three-day rule and guidance pertaining to billing non-diagnostic outpatient services.

This article will provide an overview of CMS' three-day rule and how to correctly bill for pre-admission diagnostic and non-diagnostic outpatient services.

What is the Three-day Rule?

If an admitting hospital (or an entity wholly-owned, wholly-operated, or under arrangement with the admitting hospital) furnishes **diagnostic services** three days prior to and including the date of a beneficiary's inpatient admission, the services are considered inpatient services and are included in the inpatient payment, i.e. bundled.[1] However, if a hospital renders **non-diagnostic outpatient services** three days prior to and including the date of a beneficiary's inpatient admission and the non-diagnostic outpatient services are **unrelated** to the inpatient admission, the hospital is permitted to separately bill Medicare Part B for the non-diagnostic outpatient services, i.e. unbundled. Nonetheless, there is a caveat to the three-day rule. More specifically, if the **non-diagnostic outpatient services** are **related** to the inpatient admission, the services are considered inpatient services and cannot be billed separately under Medicare Part B. See Diagram 1.

It is important to note that while hospitals are permitted to bill unrelated non-diagnostic outpatient services separately under Medicare Part B, they are not required to do so. When hospitals choose not to bill Part B for unrelated non-diagnostic outpatient services this could result in revenue loss for the organization. While billing unrelated non-diagnostic services is at the hospital's discretion, hospitals must report related non-diagnostic outpatient services on an inpatient claim.

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[1] Exception: Unless there is no Medicare Part A coverage.

How to Follow the Three-day Rule?

CMS' three-day rule relies on definitions. Although it may initially appear as trivial, complying with the policy depends on meeting the terms of the definitions. Hospitals must understand the following definitions related to the three-day rule in order to be in compliance:

- **Three-day window**: is the three days prior to and including the date the beneficiary is admitted as an inpatient. For example, if a beneficiary is admitted as an inpatient on Wednesday, then Sunday, Monday, Tuesday, or Wednesday are part of the three-day window.

- **Diagnostic service:** CMS defines diagnostic service as the presence of one of the revenue and/or Current Procedural Terminology (CPT) codes outlined in Table 1 reported on a claim. It should be noted that diagnostic services also include clinical diagnostic laboratory tests.

- **Non-diagnostic outpatient service:** is a service not identified by a diagnostic service revenue code or CPT code, i.e. Table 1.

- **Related non-diagnostic outpatient service:** is the exact match of all digits between the International Classification of Diseases Ninth Revision Clinical Modification (ICD-9-CM) principal diagnosis code assigned for both the non-diagnostic outpatient service and the inpatient stay.

- **Unrelated non-diagnostic outpatient service:** occurs when the ICD-9-CM principal diagnosis codes assigned to the non-diagnostic outpatient service and the inpatient stay do not match.

- **Wholly-owned or operated entity:** the hospital is the sole owner or operator of the entity. The hospital does not need to exercise administrative control over the entity. Further, the hospital is considered the sole operator of an entity if it has the exclusive responsibility for implementing the entity's policies. The hospital does not need to have the authority to make the policies of the entity.

Overall, a hospital can bill under the three-day rule when appropriate if it understands and meets the definitions outlined above. Failure to comply with the definitions can lead to inaccurate coding and billing which in turn results in a rejected claim and/or delayed payment.

What are the Risks Related to Noncompliance?

Both CMS and the Office of Inspector General (OIG) are watchful for instances of noncompliance with the three-day rule, especially noncompliance that results in an overpayment. Since many pre-admission outpatient services are calculated into the inpatient payment, providers are paid twice if they bill for these services separately under Medicare Part B. The separate outpatient payment amounts to an overpayment.

CMS is recovering overpayments related to the three-day rule through the Recovery Audit Contractor (RAC) program. The three-day rule is specifically on the list of targeted issues for Health Data Insights, Inc., the RAC for region D. As with other targets, the RAC will recover overpayments from claims paid on or after October 1, 2007. For the three-day rule, this means they will identify paid outpatient claims that occurred during the three days prior to an inpatient stay and should have been bundled with the inpatient claim. The RACs for regions A, B, and C do not currently include the three-day rule on their target lists. However, it is a likely addition as they continue to update their lists.

The OIG is also matching outpatient and inpatient services to identify inappropriately unbundled claims. The agency recently investigated three-day rule bundling using data mining. They plan to continue their investigations with more sophisticated data analysis tools, including a national claims database that can match claims from Medicare parts A, B, and C.

Providers face investigations and overpayment recoveries when they fail to bundle services, but they also lose out on appropriate payments if they bundle all non-diagnostic pre-admission outpatient services. With the recent clarifications from CMS, providers are discovering they have often been under-paid for non-diagnostic pre-admission outpatient services due to not fully understanding the three-day rule requirement.

How to Reduce Your Risk of Noncompliance?

Providers can reduce the chances of both overpayments and underpayments for three-day rule bundling by ensuring that everyone involved in the coding and billing process is educated on the rule and the necessary procedures for effective three-day rule billing. The first step is to create a policy that clearly explains the requirements and details the procedures that should be follow to be in compliance. These procedures should address outpatient and inpatient matching and identify the specific instances, outline above, in which outpatient services are bundled with the inpatient claim. Since coding and billing staff cannot identify all outpatient claims on their own, providers may want to include in the policy a tracking mechanism involving outpatient and admission departments. For example, admission staff can ask all patients whether they have received outpatient services in the three days prior to admission. This information can then be passed on to the coding and billing staff.

Once the policy is in place, the next step is to educate staff on the policy. Education sessions should be held for all departments involved in the process. They should address both the three-day rule regulatory requirements and the procedural requirements of the organization's policy. In addition to ensuring all staff are aware of the policy and the requirements, education provides a venue for any questions or concerns they may have.

The final step to promoting compliance within the organization is to add the three-day rule policy and procedures to auditing and monitoring plans. These can include reviewing the tracking mechanism and communications between departments, reviewing claims to ensure outpatient services are only bundled when appropriate, and logging claims returned due to noncompliance with the three-day rule.

Conclusion

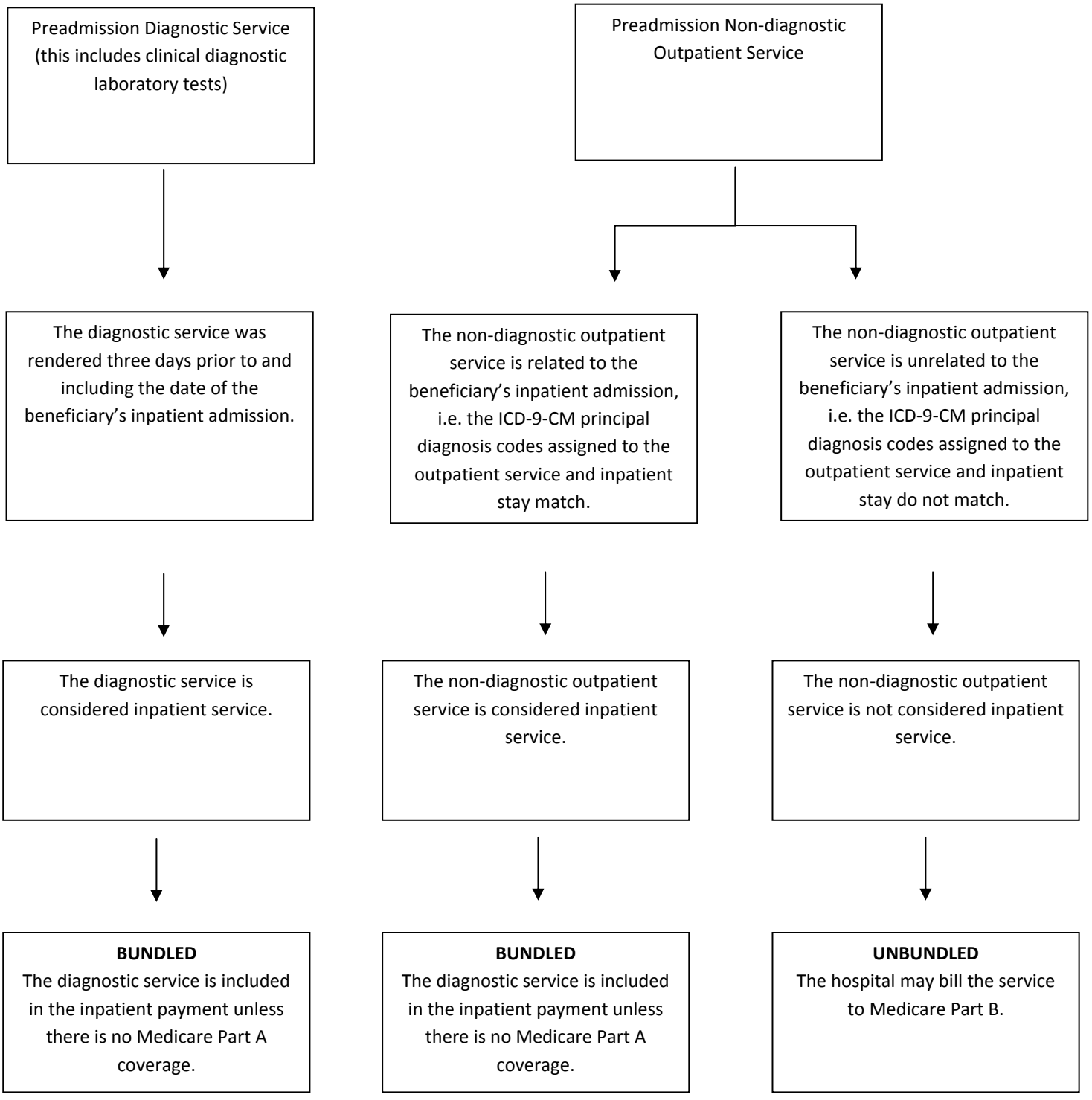
As described above, noncompliance with the three-day rule requirements can result in overpayments and underpayments. Coding and billing staff can decrease the risks of both through developing a policy and procedure for matching outpatient services to inpatient claims. At the same time, the coding and billing staff acting alone cannot ensure complete compliance with the requirements, due to the difficulties of accurately identifying outpatient claims. Compliance requires a collaborative process, involving all departments in tracking patients as they pass from the outpatient departments to inpatient status.

Table 1: Diagnostic Service Revenue and CPT Codes*

Revenue Code	Descriptor	CPT Code	Description
0254	Drugs incident to other diagnostic services	93501	Right heart catheterization
0255	Drug incident to radiology	93503	Insertion and placement of flow directed catheter (e.g., swan-ganz) for monitoring purposes
030X	Laboratory	93505	Endomyocardial biopsy
031X	Laboratory pathological	93508	Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization
032X	Radiology diagnostic	93510	Left heart catheterization, retrograde, from the brachial artery, axillary artery or femoral artery; percutaneous
0341	Nuclear Medicine: Diagnostic	93526	Combined right heart catheterization and retrograde left heart catheterization
0343	Nuclear Medicine: Other (Diagnostic Radiopharmaceuticals)	93541	Injection procedure during cardiac catheterization; for pulmonary angiography
035X	CT scan	93542	Injection procedure during cardiac catheterization; for selective right ventricular or right atrial angiography
0371	Anesthesia incident to radiology	93543	Injection procedure during cardiac catheterization; for selective left ventricular or left atrial angiography
0372	Anesthesia incident to other diagnostic services	93544	Injection procedure during cardiac catheterization; for aortography
040X	Other imaging services	93556	Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)
046X	Pulmonary function	93561	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

Revenue Code	Descriptor	CPT Code	Description
0471	Audiology diagnostic	93562	Indicator dilution studies such as dye or thermal dilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output
0481	Cardiology: Cardiac catheter lab	*Revenue and CPT codes are based on CMS table outlined in its Medicare Claims Processing Manual, Pub. 100-04, Ch. 3, sec. 40.3(B), Preadmission Diagnostic Services.	
0489	Cardiology: Other cardiology		
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		

Diagram 1: When Should You Bundle?[2]



[2] Diagram 1 applies to hospitals subjected to the inpatient prospective payment system.

Official References

- 42 CFR § 412.2
- Medicare Claims Processing Manual Chapter 3, Section 40.3: Outpatient Service Treated as Inpatient Services.
- "CMS: Hospitals Can Skip Charges for Non-diagnostic in 3-day Window." Report on Medicare Compliance Vol. 19, No.6, 15 Mar. 2010: 5-6.