



Reviewing the Three-day Rule

Posted By Debbie Mackaman On March 8, 2010 (1:25 pm) In [IPPS](#), [OPPS](#)

Last week during the CMS Hospital Open Door Forum, CMS responded to requests for clarification on whether non-diagnostic services that are **unrelated** to the inpatient admission **must** be billed separately as outpatient services. To understand the implications of the CMS representative's response, let's look at the differences between diagnostic and non-diagnostic outpatient services and related vs. unrelated to the inpatient admission.

Diagnostic services are considered to be packaged into the inpatient payment when they are provided to a patient by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital, within three days prior to and including the date of the patient's admission. This includes those services provided "under arrangement" by another provider. The [Medicare Claims Processing Manual, Chapter 3, Section 40.3](#), provides a list of the revenue codes, and in some cases HCPCS codes, that identify services as diagnostic. To be correctly apply the three-day rule, hospitals also need to understand the definition of "wholly owned or operated" by the hospital – that is, the hospital is the sole owner or operator of the facility providing the outpatient service and the hospital has exclusive responsibility for implementing that facility's policies or overseeing that facility's routine operations. The ownership, revenue codes, and sometimes the HCPCS codes clearly drive the application of the three-day rule for diagnostic services.

Non-diagnostic outpatient services (those not identified by a diagnostic service revenue code) can also be packaged into the inpatient payment using the same definition of "wholly owned and operated" and if the services were provided within three days prior to and including the date of the patient's admission. However, the difference is that the non-diagnostic services must be **related** to the admission. In 1998, CMS defined non-diagnostic preadmission services as being related to the admission only when there is an exact match (all digits) between the ICD-9-CM principal diagnosis code for the inpatient stay and the first-listed diagnosis code for the preadmission services. If the services are **not related** to the admission, the hospital **may** separately bill the non-diagnostic preadmission services to Part B.

During the Open Door Forum call, the CMS representative responded to the requests for clarification, saying that, "It is *mandatory* that unrelated services cannot be included in the bill for inpatient admission; however, it's *discretionary* to bill them separately as outpatient services." In addition, the representative stated this rule has not changed since its implementation.

So what does this mean to hospitals? By including unrelated non-diagnostic services on the inpatient claim, the hospital may be inappropriately eligible for an outlier payment. According to CMS, hospitals **must** distinguish between the related and unrelated services to be included on the inpatient claim. On the other hand, a hospital may choose not to bill Part B for the unrelated non-diagnostic services, since

CMS has stated it is **discretionary** to do so; however, the hospital could be losing revenues for those separately reimbursable services and potentially creating an unforeseen inducement.



Based on this CMS response and that the Region D RAC has recently added the three-day rule to its list of approved issues, hospitals should take the time to review their current procedures on how non-diagnostic services are identified as related or unrelated and what their current processes are for including only the related non-diagnostic services on their inpatient claims. This may be one of those instances where hospitals cannot rely on an automated process alone. Also, hospitals should be aware of potential delays in filing claims for non-diagnostic outpatient services, since the first-listed diagnosis must be compared to the principal diagnosis of the inpatient stay to correctly make the determination to include those services on the inpatient claim.

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