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Acute-Care Hospitals: A Peek Inside the Payment Window

2/18/2025

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Objective

Assist ACHs with preventing claim rejections by providing a review of the three-day payment window policy and instructions for submitting claims that comply with this policy.

Today’s Presenters

- Provider Outreach and Education Consultants
  - Christine Janiszcak
  - Jean Roberts, RN, BSN, CPC

Agenda

- [Three-day Payment Window Policy Overview]
- [Admitting Hospital]
- [Timeframe]
- [OP Diagnostic Services]
- [OP Nondiagnostic Services]
- [Policy Does Not Apply To…]
- [Policy Does Not Apply When…]
- [Claim Rejections]
- [References]
- [Questions]

Three-day Payment Window Policy – Overview

Did You Know…

- A three-day payment window policy applies to admitting hospitals paid under the IPPS (ACHs)

Other Names for Three-Day Payment Window

- Preadmission services window
- DRG window
- Payment rule
- Payment window
- 72-hour rule
- 72-hour window
- Three-day rule
- Bundled/bundling
- OP services treated as IP

A Peek Inside the Window

- Being familiar with CMS' long-standing three-day payment window policy can help you
    - Submit claims to Medicare correctly
    - Prevent claim rejections and returns

Three-Day Payment Window Policy – General Rule (Continued)

- When three-day payment window policy applies, admitting ACH
  - Adds **certain** OP diagnostic services and/or nondiagnostic services rendered to beneficiary to IP claim when
    - Beneficiary admitted to ACH as IP and
    - **Admitting ACH** rendered such OP services on and/or within three days prior to beneficiary's IP admission date
  - Does not submit separate OP claim
    - These services deemed to be IP services; paid for within DRG

Three-Day Payment Window Policy – General Rule

- Policy applicable when Medicare Part A can pay for IP ACH claim
  - Part A can pay for IP ACH claim when
    - Beneficiary entitled to Part A
    - Beneficiary has IP hospital benefit days under Part A available
    - IP stay covered by Part A (medically R&N)

Assumption for This Presentation

- Unless stated otherwise, assume
  - Medicare Part A can pay for IP ACH claim and
  - Three-day payment window policy applies

Three-Day Payment Window Policy – Report OP Services on IP Claim

- To add OP services to IP claim; report
  - OP services revenue code(s) and charges
  - OP services procedure code(s) and date(s)
  - OP services diagnosis code(s)
  - Admission (admit) date = date beneficiary formally admitted as an IP
  - From date = earliest OP DOS added
- Could result in a DRG change

Three-day Payment Window Policy – Admitting Hospital

Admitting Hospital - Defined

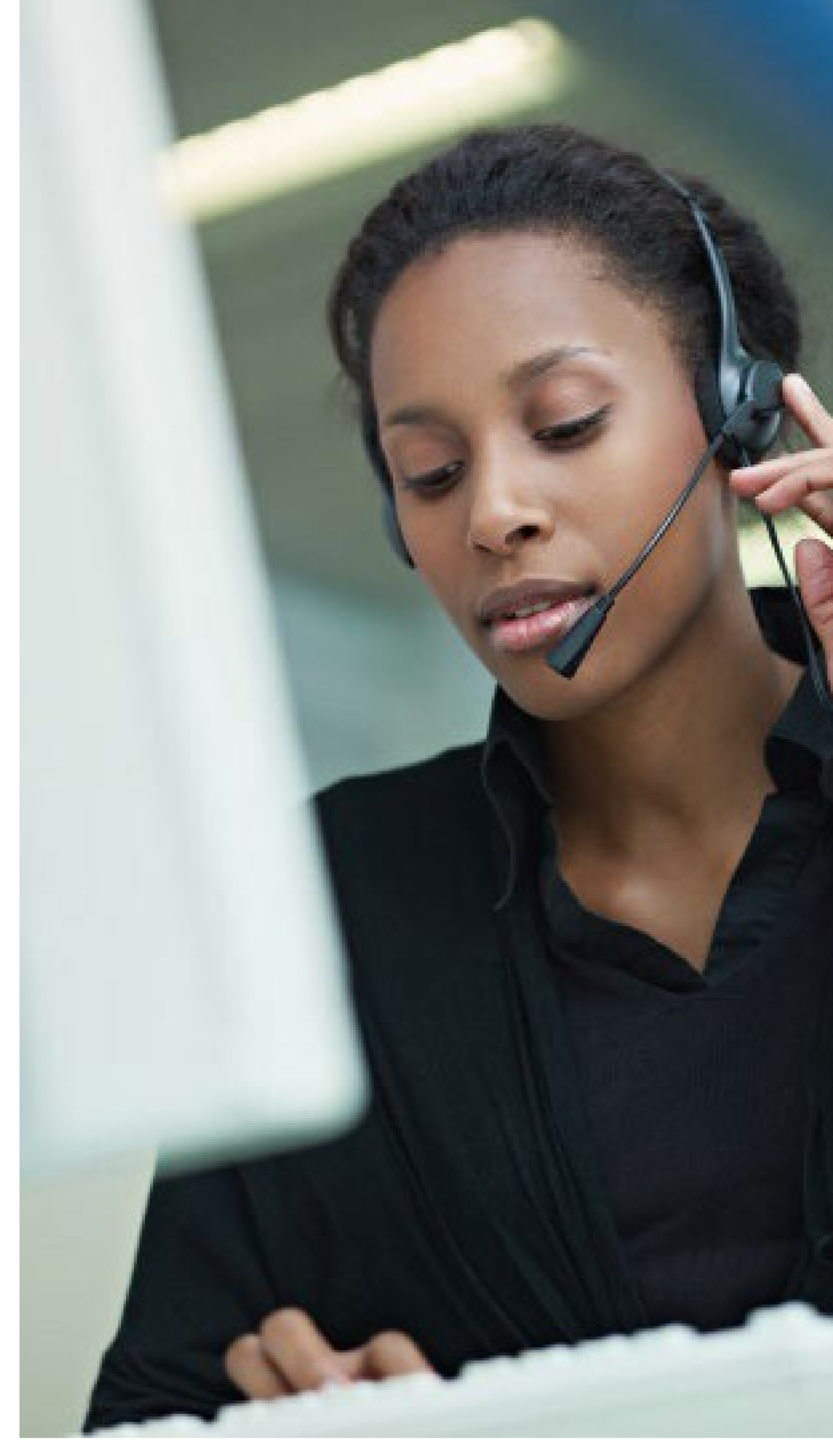
- Hospital that formally admits beneficiary as IP
  - Term also includes
    - Entity wholly owned or wholly operated by admitting hospital or
    - Entity under arrangement with admitting hospital
- When either of above applies
  - Add **technical portion** of OP service(s) to IP claim, when applicable

Wholly Owned or Wholly Operated

- Hospital is sole owner or sole operator
  - Hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing facility's routine operations), regardless of whether it also has authority to make policies
- Wholly owned or wholly operated entities defined in 42 CFR, Section 412.2

Did You Know….

- When determining if the three-day payment window applies, the admitting hospital must consider the OP services it rendered, and the OP services rendered by provider-based departments and clinics that it wholly owns and/or wholly operates.



Admitting Hospital Notifies Part B Entities of IP Admission

- Admitting hospital must make wholly owned or wholly operated physician's office or other Part B entity aware of IP admission
  - Physician's office/other Part B entity
    - Appends modifier PD on CMS-1500 claim form or electronic equivalent, to applicable services rendered during payment window

Three-day Payment Window Policy – Timeframe

Three-Day Payment Window – Timeframe

- OP services rendered to beneficiary
  - On IP admission date and
  - Within three days prior to IP admission date
- You must consider a total of four days

Three-Day Payment Window – Day Count

- How to count three days – Example
  - If IP admission date = 4/15
    - Review all following dates to determine if admitting hospital (or entity that falls under this definition) rendered OP services it must add to IP claim
      - 4/15 (IP admission date)
      - 4/14 (one day prior to IP admission date)
      - 4/13 (two days prior to IP admission date)
      - 4/12 (three days prior to IP admission date)

Three-day Payment Window Policy – OP Diagnostic Services

OP Diagnostic Services – Defined

- OP diagnostic services defined by presence of certain revenue, CPT and HCPCS codes on OP claim
  - CMS maintains list in CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 40.3

OP Diagnostic Services Rendered on and/or Within Three Days Prior to IP Admission Date

- Admitting hospital
  - Must add OP diagnostic services to IP claim, regardless of relationship to IP admission, when rendered
    - On IP admission date and/or
    - Within three days prior to IP admission date
  - Must not submit separate OP claim

OP Diagnostic Services Revenue Codes and Descriptions

- 0254 = Pharmacy, drugs incident to other diagnostic services
- 0255 = Pharmacy, drugs incident to radiology
- 030X = Laboratory
- 031X = Laboratory – pathological
- 032X = Radiology – diagnostic
- 0341 = Nuclear medicine – diagnostic procedures
- 0343 = Nuclear medicine – diagnostic radiopharmaceuticals
- 035X = Computed tomographic scan
- 0371 = Anesthesia – incident to radiology

OP Diagnostic Services Revenue Codes and Descriptions

- 0372 = Anesthesia – incident to other diagnostic services
- 040X = Other imaging services
  - Except 0403 = screening mammogram
- 046X = Pulmonary function
- 0471 = Audiology – diagnostic
- 0481 = Cardiology – cardiac cath lab
- 0482 = Cardiology – stress test
- 0483 = Cardiology – echo cardiology
- 0489 = Cardiology – other cardiology

OP Diagnostic Services Revenue Codes and Descriptions

- 053X = Osteopathic services
- 061X = Magnetic Resonance Technology
- 062X = Medical/surgical supplies
- 073X = Electrocardiogram
- 074X = Electroencephalogram
- 0918 = Behavioral health treatment/services testing
- 092X = Other diagnostic services
- Note:
  - For revenue codes 0481 and 0489, CPT/HCPCS codes = 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571, 93572, G0275 and G0278 diagnostic (Refer to rejection reason code C7109 for more coding)

OP Diagnostic Services – Example

- Beneficiary
  - Receives OP services for revenue code 032X (diagnostic radiology) at ACH on 4/12, 4/13, 4/14, and/or 4/15
  - Admitted as IP to same ACH on 4/15
- Admitting ACH
  - Adds OP services for revenue code 032X to IP claim

Three-day Payment Window Policy – OP Nondiagnostic Services

OP Nondiagnostic Services Defined

- Presence of certain revenue, CPT and HCPCS codes on OP claim
  - CMS does not maintain list
  - Revenue, CPT and HCPCS codes not on CMS' diagnostic services list

OP Nondiagnostic Services Rendered on IP Admission Date

- Admitting hospital
  - Must add OP nondiagnostic services to IP claim, regardless of relationship to IP stay, when rendered on IP admission date
  - Must not submit separate OP claim

OP Nondiagnostic Services Rendered Within Three Days Prior to IP Admission Date

- Admitting hospital
  - Must add OP nondiagnostic services to IP claim if **related to IP stay,** when rendered within three days prior to IP admission date
  - May submit separate OP claim (13x) if services **not related to IP stay**
    - Report CC 51 to attest services clinically distinct/independent from reason for IP stay
      - Claim subject to review
      - Must have documentation
      - Clinical decision

Inpatient-Only Procedure Rendered in OP Setting Prior to IP Admission

- Treat same as OP nondiagnostic services
  - Admitting hospital must add service to IP claim when
    - Rendered on IP admission date regardless of relationship to IP stay
    - Rendered within three days prior to IP admission and related to IP stay
- References:
  - CR7443 and CR9097

OP Nondiagnostic Services Rendered on IP Admission Date – Example

- Beneficiary
  - Receives OP services for revenue code 045X (ER) at ACH on 4/15
  - Admitted to same ACH as IP on 4/15
- Admitting ACH
  - Adds OP services for revenue code 045X to IP claim

OP Nondiagnostic Services Rendered Prior to IP Admission Date – Example

- Beneficiary
  - Receives OP services for revenue code 045X (ER) at ACH on 4/12, 4/13, and/or 4/14
  - Admitted to same ACH as an IP on 4/15
- Admitting ACH
  - Determines if OP services are clinically distinct/independent from reason for IP admission
    - If no, adds services to IP claim
    - If yes, submits OP claim (TOB 13X) with CC 51

Three-day Payment Window Policy – Does Not Apply to…

Ambulance and Maintenance Dialysis Services

- When rendered within payment window timeframe
  - Submit separate OP claim (13x) for
    - Ambulance services (revenue code 0540)
    - Maintenance dialysis services (Refer to [CR7142] for coding)
  - Do not add to IP claim

OP Nondiagnostic Services Not Payable Under Part B

- Per CR8041, payment window does not apply to OP nondiagnostic services not payable under Part B
  - Example: Oral medications (self-administered drugs) not payable under Part B
- Per CR9097, exception to above policy for related IP-only procedures rendered in OP setting
  - If related IP-only procedure rendered in OP setting within three days prior to IP admission date, add such services to IP claim

Certain Provider Types/Services

- Payment window does not apply to
  - Part A services by SNFs, HHAs and hospices
  - OP services included in RHC or FQHC all-inclusive rate
  - CAHs unless wholly owned or wholly operated by a non-CAH

OP Services Rendered More Than Three Days Prior to IP Admission Date

- Submit OP services rendered more than three days prior to IP admission date on separate OP claim; do not add to IP claim
  - Even when all services rendered during one continuous OP encounter that spans multiple dates
    - Examples of services that may span multiple dates
      - ER encounter (revenue code 0450)
      - Observation (revenue code 0762)

ER Encounter (Revenue Code 0450) if Date Entered ER Is Outside Payment Window

- If ER encounter spans more than one calendar day
  - Determine **date beneficiary entered ER**
    - If outside payment window, submit OP claim
      - For ER encounter, report revenue code 0450 with LIDOS = date entered ER
      - For other ER services, report LIDOS = actual DOS
    - If within payment window, add ER encounter to IP claim
      - For other ER services, review revenue codes for payment window policy
- Reference:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 180.6

Observation (Revenue Code 0762) if Date Began Is Outside Payment Window

- If observation spans more than one calendar day
  - Determine **date observation care began**
    - If outside payment window, submit OP claim
      - Report revenue code 0762 and all hours of entire observation period on single line with LIDOS = date observation began
    - If within payment window, add service to IP claim
- Reference:
  - CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 4, Section 290.2.2

Three-day Payment Window Policy – Does Not Apply When…

Medicare Part A Cannot Pay for Inpatient Claim

- Part A cannot pay for IP claim when
  - Beneficiary not entitled to Part A
  - IP hospital Part A benefit days exhausted
  - IP stay not covered (i.e., not medically R&N)
    - Per MAC, Medical Review Contractor or hospital's self-audit

Did You Know…

- In CR7672, CMS clarified that in situations where there is no Part A coverage for an IP stay, there is no IP service into which OP services must be bundled. Therefore, OP services provided to a beneficiary prior to an IP admission (i.e., IP admission order) may be separately billed to Part B as the "OP services that they were".

Billing of Payment Window Services When No Part A or Part A Benefits Exhausted

- If Part A cannot pay for IP claim because beneficiary not entitled to or exhausted Part A benefit days, submit
  - TOB 13x and/or 14X for OP payment window services
  - TOB 12X for billable IP services
  - TOB 110 for IP stay if IP hospital benefit days exhausted at admission
- References:
  - CMS IOM Publications
    - 100-02, *Medicare Benefit Policy Manual, Chapter 6*, Section 10.2
    - 100-04, *Medicare Claims Processing Manual, Chapter 4*, Section 240

Billing of Payment Window Services When IP Hospital Stay Is Not Covered

- If Part A cannot pay for IP claim because beneficiary's IP stay not covered (i.e., not medically R&N)
  - Per decision by MAC or Medical Review Contractor
    - Submit appeal of IP denied claim or
    - Submit appropriate claims if Part A to B rebilling criteria met
    - Refer to CRs 8445 and 8666
  - Per decision by hospital during self-audit
    - Follow CRs 8445 and 8666

Three-day Payment Window Policy – Claim Rejections

Reason Code C7109

- Incoming OP claim
  - Through date > IP admission date – four days or = IP admission date and
  - One or more diagnostic services present
- Action:
  - Verify statement covers period, revenue and CPT/HCPCS codes billed
  - If diagnostic services rendered on and/or within three days of IP admission, remove from OP claim
  - If any payable services remaining on OP claim, claim will process
  - Adjust IP claim to add OP diagnostic services
    - TOB = **117** and CC = **D1**

Reason Code C7114

- Incoming OP claim
  - Through date = or within three days of admission date of IP admission to your facility
  - OP claim has nondiagnostic services which may be related to IP stay
- Action:
  - Verify statement covers through date
  - If nondiagnostic services rendered on IP admission date (regardless of relationship to IP stay) or if rendered within three days prior to IP admission date (and related to IP stay), adjust IP claim to add services
    - TOB = **117** and CC = **D1**
  - If nondiagnostic services rendered within three days prior to IP admission date (and not related to IP stay), add CC 51 to OP claim

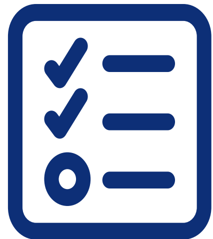
Reason Code C7113

- Incoming IP claim
  - Admission date < four days after through date on OP claim from your facility and
  - OP claim for diagnostic services only
- Action
  - Cancel OP claim
    - TOB = **XX8** and CC = **D6**
  - Resubmit correct IP claim

Reason Code C7115

- Incoming IP claim
  - Admission date = or within three days of through date of processed OP claim
  - OP claim has **nondiagnostic services** that may be related to IP admission
- Action:
  - Verify IP admission date and statement covers period on paid OP claim
  - If all OP nondiagnostic services related to IP stay, cancel OP claim
    - TOB = **XX8** and CC = **D6**
  - If some nondiagnostic services related to IP stay, adjust OP claim to remove
    - TOB = **XX7** and CC = **D1**
    - Note: May need to add CC 51 to OP claim to explain any remaining unrelated nondiagnostic services rendered within three days prior to IP admission date
  - Resubmit correct IP claim

Preventing Claim Rejections



Policy
Be familiar with policy guidelines including day count

Revenue Codes
Review OP revenue codes to categorize services as diagnostic or nondiagnostic and apply guidelines

Wholly Owned/Wholly Operated
Be aware of which entities wholly owned/wholly operated

Add to IP Claim or Submit OP Claim
Understand when you can or cannot separately bill for OP services

Admitting Hospitals Must Not Submit Separate OP Claim For…

- OP diagnostic services rendered
  - On IP admission date and/or
  - Within three days prior to IP admission date
- OP nondiagnostic services rendered
  - On IP admission date
    - Regardless of relationship to IP admission
  - Within three days prior to IP admission date
    - If services clinically associated with reason for IP admission (assumed to be unless hospital attests that they are not)

Admitting Hospitals May Submit Separate OP Claim For…

- OP nondiagnostic services rendered within three days prior to IP admission date
  - If services clinically distinct or independent from reason for IP admission (hospital attests to this by reporting CC 51 on OP claim)
  - Notes
    - Must have documentation to support CC 51
    - Claim may be subject to review
    - Claim must meet all applicable filing deadlines

What You Should Do Now

- Review references
- Be familiar with three-day payment window
- Establish and implement procedures to comply with policies
- Submit claims accurately
- Share today's presentation with other staff members
- Attend future education

Three-day Payment Window Policy – References

CMS References

- Code Federal Regulations: 42 CFR 413.40 (c) (2)
- Acute Inpatient PPS
- Three-Day Payment Window web page
  - Memorandum: Implementation of New Statutory Provision Pertaining to Medicare 3-Day Payment Window (8/9/2010)
  - FAQs for CR 7502: Medicare's 3-Day Payment Window and the Impacts on Wholly Owned or Wholly Operated Physician Practices (6/14/2012)
- CMS-1599-F
- MLN Matters® *SE20024; FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients*

CMS Internet-Only Manuals

- Publication 100-02, *Medicare Benefit Policy Manual*
  - Chapter 6, Sections
    - 10.1 “Reasonable and Necessary Part A Hospital Inpatient Claim Denials”
    - 10.2 “Other Circumstances in Which Payment Cannot Be Made Under Part A”
    - 10.3 “Hospital Inpatient Services Paid Only Under Part B”
- Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 3, Section 40.3 “OP Services Treated as IP Services”

CMS Internet-Only Manuals (continued)

- Publication 100-04, *Medicare Claims Processing Manual*
  - Chapter 4, Sections
    - 10.12 “Payment Window for OP Services Treated as IP Services”
    - 180.6 “Emergency Room Services That Span Multiple Service Dates”
    - 180.7 “Inpatient-Only Services”
    - 240.5 “Payment of Part B Services in Payment Window for OP Services Treated as IP Services When Payment Cannot Be Made Under Part A”
    - 290.2.2 “Reporting Hours of Observation”
  - Chapter 12, Sections
    - 90.7 “Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (Physician Practices and Clinics): 3-Day Payment Window”
    - 90.7.1 “Payment Methodology 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (Physician Practices and Clinics)”

CMS Change Requests

- CR7142 – Clarification of Payment Window for OP Services Treated as IP Services
- CR7443 – July 2011 Update of the Hospital OPPS (#7)
- CR7502 Revised – Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly-Owned or Wholly-Operated Physician Practices
- CR7672 Revised – January 2012 Update of the Hospital OPPS
- CR8041 Revised – FY 2013 IPPS & LTCH Changes
- CR8046 – Modification of Payment Window Edit in the CWF to Modify Diagnostic Service List
- CR8185 – CMS Administrator's Ruling: Part A to Part B Rebilling of Denied Hospital IP Claims

CMS Change Requests (continued)

- CR8445 Revised – Implementing Part B IP Payment Policies from CMS-1599-F
- CR8666 – Implementing Part B IP Payment Policies from CMS-1599-F
- CR9097 Revised – April 2015 Update of Hospital OPPS
- CR11312 – Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication
- CR11559 – Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent With Current Policy
- CR13136 – April 2023 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- CR13182 Correction to Payment Window Edits for Inpatient Prospective Payment System (IPPS)-Excluded Hospitals and IPPS-Excluded Units

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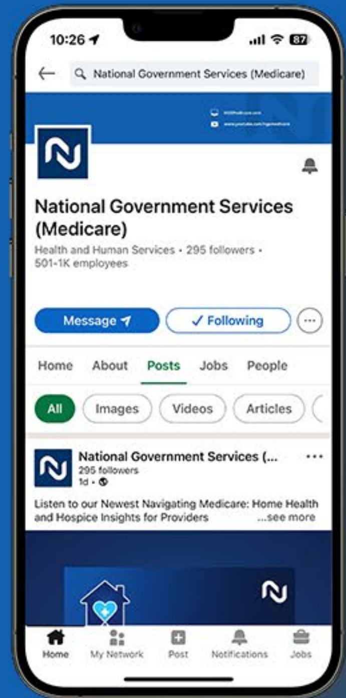

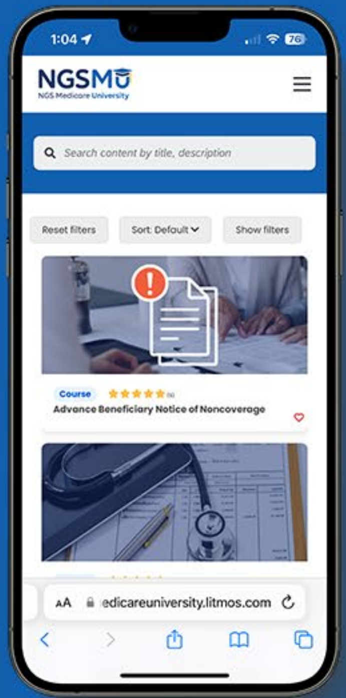

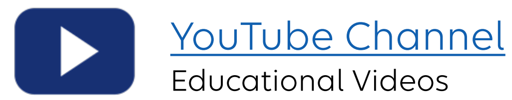

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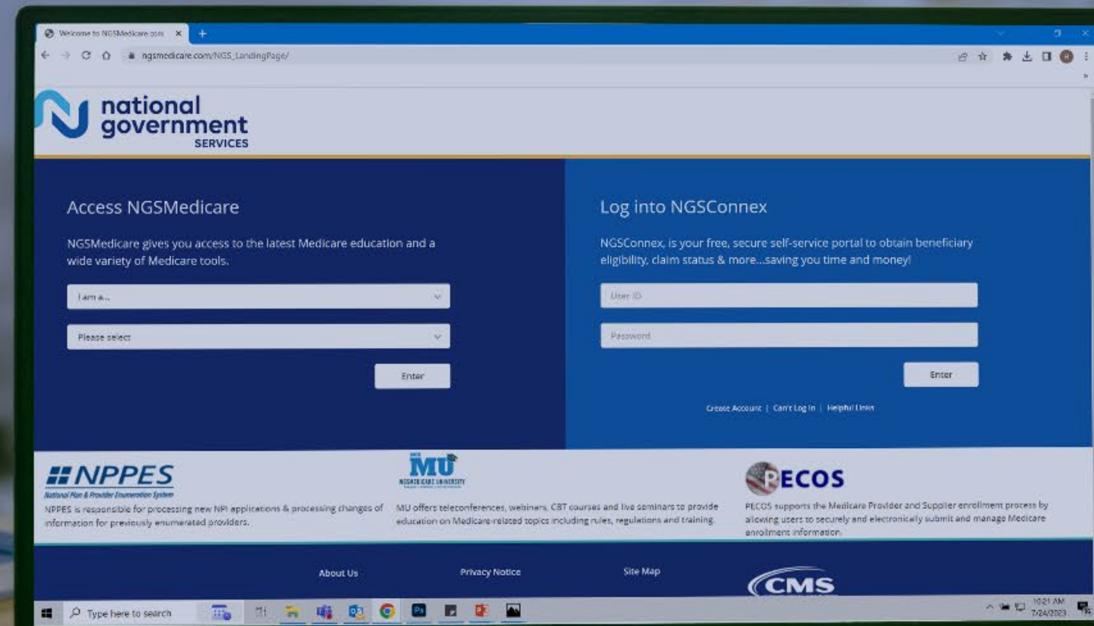

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