DIGNITY HEALTH
ADMINISTRATIVE POLICY AND PROCEDURE

FROM: Dignity Health Compliance Oversight Committee

SUBJECT: Three Day/One Day Window/Pre-admission Services

EFFECTIVE DATE: June 22, 2012

REVISED: June 22, 2012; December 17, 2010, April 23, 2010, February 1, 2007; March 1, 2005; (9.110) March 7, 2003; February 15, 2001

ORIGINAL EFECTIVE DATE: (9.110) February 15, 2001

REPLACES: (9.110) Three Day Window/Pre-admission Services: February 15, 2001; March 7, 2003

APPLIES TO:

System Offices:	_____
Acute Care Entities:	X
Non-acute Care Entities:	X

I. POLICY:

Under Medicare rules, a hospital (or an entity that is "wholly owned and/or operated by the hospital") may not:

1) Bill for diagnostic services provided to a patient in the (3) calendar days[1] prior to the date of admission; or
2) Bill for non-diagnostic services provided to a patient in the three (3) calendar days[1] prior to the date of admission; if such non-diagnostic services are related to the admission.

Diagnostic and non-diagnostic services provided the day of admission must always be rolled into the inpatient admission charges and claim

Hospitals which have clinics or other entities that provide services (other than ambulance and maintenance renal dialysis) that are "wholly owned or operated by the hospital" must ensure that services and charges are properly rolled into the DRG and not separately billed

The forgoing limitation does not apply to services that are clearly unrelated to the admission..

[1] For purposes of this policy, certain hospitals, including critical access hospitals, psychiatric hospitals, inpatient rehabilitation hospitals and cancer centers are not paid on IPPS basis can substitute "one (1) calendar day" for "three (3) calendar days" in this policy.

II. DEFINITIONS:

Wholly Owned or Wholly Operated - An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.

PD (payment modifier) – Diagnostic or related non-diagnostic item or service or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within 3 days of services provided.

Condition Code 51 - Attestation of unrelated outpatient diagnostic services.

Unrelated Services - The preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's inpatient admission.

Related Services - Those non-diagnostic services that are furnished in connection with the principal diagnosis assigned to the inpatient admission that require the beneficiary to be admitted to inpatient and clinically associated with reason for admission.

Attest (for purposes of this regulation) - Facility has been able to determine through internal processes that outpatient services provided within three day window of acute admission are not related; documentation is maintained to support this work.

Physician Services - professional services provided to beneficiaries which are processed either by the hospital or separately by the physician. These services are reported on the CMS 1500 form, and reimbursed according the Medicare Physician Fee Schedule (MPFS).

III. PRINCIPALLY AFFECTED DEPARTMENTS:

The following entities are principally affected by the policy elements and shall receive the required training, as provided in Administrative policy number 70.1.003, *Compliance Policy Dissemination and Implementation Process.*

The following entities are principally affected by the policy elements and shall receive the required training, as provided in Administrative policy 70.1.003, Compliance Policy Dissemination and Implementation Process:

- Hospitals
- Central Business Offices (CBOs) / Billing Offices

Specifically, the following departments:

- Admitting / Registration
- Coding
- HIM / Medical Records
- Patient Financial Services / Billing Departments
- Facility President / Senior Management

A Dignity Health entity may, in the exercise of its reasonable judgment, determine that other departments are affected by this policy and provide necessary training to the workforce in those departments.

IV. GUIDELINES:

Under the 3-day payment window, a hospital must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission related outpatient non-diagnostic services provided during the payment window. All services other than ambulance and maintenance renal dialysis services, provided by the hospital on the same date of admission are deemed related to the admission and are not separately billable regardless of whether the inpatient and outpatient diagnosis(s) are the same.

Additionally, outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis provided within the 3-day window leading up to including admission are deemed "related" to the admission and thus must be billed with the inpatient stay, unless the hospital "attests" to specific non-diagnostic services as being unrelated to the hospital claim (therefore clinically distinct or independent for reason for beneficiary's admission) by adding condition code 51 to the separately billed outpatient claim under Part B services.

When an entity that is wholly owned or wholly operated by a hospital furnishes a service subject to the 3-day window policy, Medicare will pay the professional component of services with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split. Once the entity has received confirmation of a beneficiary's inpatient admission from the admitting hospital, they shall, for services furnished during the 3-day window, append a CMS payment modifier to all claim lines for diagnostic services and for those non-diagnostic services that have been identified as related to the inpatient stay. Physician non-diagnostic services that are unrelated to the hospital admission are not subject to the payment window and shall be billed without the payment modifier.

CMS has established new payment modifier PD (Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days), and require that the modifier be appended with the entity's preadmission diagnostic and admission-related non-diagnostic services, reported with HCPCS/CPT codes, which are subject to the 3-day payment window policy. The wholly owned or wholly operated entity will need to manage their billing processes to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. Each hospital and/or entity will develop an internal process to assure compliance. The hospital is responsible for notifying the entity of an inpatient admission for a patient who received services in a wholly owned or wholly operated entity within the 3-day (or, when appropriate, 1-day) payment window prior to the inpatient stay to include notification of the physician.

Services billed with the modifier "PD" should be reimbursed at the facility rate of the MPFS (Medicare Physician Fee Schedule).

(NOTE): **Global Surgical Services and the 3-day Payment Window Policy**
CMS notes that the time frames associated with 10 and 90 day global surgical packages could overlap with the 3-day (or 1-day) payment window policy. The 3-day payment window makes no change in billing surgical services according to global surgical rules, and pre- and post-operative services continue to be included in the payment for the surgery. However, there may be times when the surgery itself is subject to the three-day window policy, as would occur if the surgery were performed within the three-day window. For example, a patient could have a minor surgery in a wholly owned or wholly operated entity and then, due to a complication, be admitted as an inpatient. In such cases the modifier shall be appended to the appropriate surgical HCPCS/CPT code.

(NOTE):Condition Code 51 - . The hospital will be required to maintain such documentation as part of beneficiary's medical record, to support its claim that services were unrelated to the admission. This will require a separate review and evaluation prior to claims submission.

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It is the responsibility of the facility Chief Financial Officer to ensure adherence to this policy.

This policy supersedes any prior or existing policy or procedure which conflicts with the statements and principals above.

V. STATUTORY/REGULATORY AUTHORITIES:

42 C.F.R. §412.2(c)(5); Medicare Hospital Manual §415.6; 63 Fed. Reg. 6864 CMS 1998 Revision to the DRG window bundling rule
Medicare Claims Processing Manual, Chapter 3, Section 40.3
Preservation of Access to Care for Medicare Beneficiary and Pension Relief Act of 2010, Pub. L, 111-192
CR7502 –issued 12/21/2011