Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal A-03-013 **Date: FEBRUARY 14, 2003**

CHANGE REQUEST 2573

SUBJECT: 3-Day Payment Window Refinements Under the Short-Term Hospital Inpatient Prospective Payment System

Section 1886(a)(4) of the Social Security Act defines the operating costs of inpatient hospital services under the prospective payment system to include certain preadmission services furnished by the hospital (or by an entity that is wholly owned or wholly operated by the hospital) to the patient up to 3 days before the date of the patient's admission to the hospital. The payment window for hospitals excluded from the short-term hospital inpatient prospective payment system includes only those services furnished during the 1 day before a patient's hospital admission. The term "day" refers to the calendar day immediately preceding the date of admission, not the 24-hour (or 72-hour) period that immediately precedes the hour of admission. Preadmission services that are subject to the payment window (covered under the inpatient payment) include diagnostic services (including clinical diagnostic laboratory tests) and nondiagnostic outpatient services that are related to a patient's hospital admission.

In the February 11, 1998, final rule (63 FR 6864), we made several refinements to the 3-day payment window provisions. Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay. Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions. Further, we revised the regulations at §§ 412.2(c)(5) and 413.40(c)(2) to exclude maintenance renal dialysis services from services that are subject to the payment window.

This Program Memorandum (PM) revises the FISS, APASS, and CWF claims processing systems to reflect the March 13, 1998, changes noted above. Additionally, this PM revises the following manuals:

- Medicare Intermediary Manual, Part 3, §3610.3 (Outpatient Services Treated As Inpatient Services) and §3670 (Detection of Duplicate Claims)
- Medicare Hospital Manual, §415.6 (Outpatient Services Treated As Inpatient Services)
- Medicare Provider Reimbursement Manual, Part I – Chapter 27, §2702.1.C (Outpatient Hospital Services Which Become Inpatient Hospital Services).

This PM also revises the revenue codes for diagnostic services in the Common Working File, §3610.3 of the Medicare Intermediary Manual, and §415.6 of the Hospital Manual to include the following:

51X - Clinic
52X - Free-standing Clinic
61X - MRT
71X - Recovery Room
75X - Gastrointestinal Services

In addition, the Common Working File must be updated to include the following revenue code for therapeutic services:

26X - IV Therapy

Reprocess any claims that were inappropriately denied due to the lack of correct editing. Do not search for claims, but reprocess those brought to your attention.

Provider Education
This information must be shared with providers through your Web site within 2 weeks and published in your next regularly scheduled bulletin.

The *effective date* for this PM is February 14, 2003.

The *implementation date* for this PM is July 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after February 28, 2004.

If you have any questions pertaining to the 3-day payment window, contact Valerie Miller (410-786-4535).