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# Complete Healthcare Compliance Manual 2024
# Revenue Cycle: 3-Day Payment Rule

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## What Is the 3-Day Payment Rule?

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 was signed into law and implemented the 3-day payment window.[4] The "3 days" refers to the three days prior to a Medicare beneficiary's admission to an inpatient hospital or a hospital's wholly owned or operated Part B entity. All diagnoses, procedures, and charges for outpatient diagnostic services and admission-related outpatient nondiagnostic services that have been furnished to the beneficiary in those three days must be billed together with a beneficiary's inpatient stay. In short, hospitals must bundle the technical component (TC) of all outpatient diagnostic services and related nondiagnostic services with the inpatient stay claim. On the other hand, if the hospital or hospital-owned entity is not paid under the Inpatient Prospective Payment System (IPPS), the required period is one day prior to the beneficiary's admission, rather than three. Thus, this rule has effectively become the 3-day or 1-day payment window rules.

This rule can be complicated to comply with when hospitals and hospitals' wholly owned or wholly operated Part B entities are compiling their billings. There are two main compliance issues with this rule: (1) understanding the differences between billing as a hospital versus a hospital's wholly owned or wholly operated Part B entity; and (2) understanding common pitfalls with interpretation of the rule, which also leads to poor billing practices. The Centers for Medicare & Medicaid Services (CMS) has released numerous policy statements to educate billers on best practices to comply with the 3-day payment window rule.

## Risk Area Governance

The primary risk of failure to comply with the rule is a Medicare audit. The laws that govern the Medicare appeals process regarding an audit for an overpayment or underpayment determination are contained in the Social Security Act, as well as various provisions in the Code of Federal Regulations.[5][6]42 U.S.C. § 1320a-7k is an important provision of the Social Security Act, as it discusses the Medicare and Medicaid program integrity provisions. It essentially explains the consequences of participating in federal healthcare fraud and how to respond when one has received an overpayment. Section 1320a-7k is tangentially related to 42 U.S.C. § 1395ddd , which further explains the Medicare Integrity Program. 42 U.S.C. § 1395ff is pertinent because it explains how determinations are made and the subsequent appeals process—a process many providers go through if they have received an overpayment or have otherwise billed incorrectly. The Code of Federal Regulations holds most of its relevant provisions in 42 C.F.R. § 405 et seq. This chapter of the Code contains 10 active subparts, all of which explain different terms and conditions to participating in Medicare. The last relevant provision of the Code is 42 C.F.R. § 424.535 . This provision details revocation of enrollment in the Medicare program; it is considered a highly important provision that all providers who bill Medicare should be aware of.

There are also potential risks for a civil monetary penalty.[7] A civil monetary penalty can be imposed for a variety of prohibited conduct, including, but not limited to: improper drug price reporting, false and fraudulent claims to any federal healthcare program or other contract or grant, illegal kickbacks pursuant to the Anti-

Kickback Statute, and violations of the Physician Self-Referral Statute (the Stark Law).

## Common Compliance Risks

The 3-day and 1-day payment windows are both codified in the Code of Federal Regulations.[8] Because this rule is centered around billing procedures, it is important to understand the payment methodology that goes into the rule. As is the case normally, when Medicare billing is involved, there are several compliance risks. CMS and the Office of Inspector General (OIG) are watchful for instances of noncompliance, especially overpayments.

### Wrongfully Calculating 3-Day Payment Window Services

Often, the services covered under the 3-day payment window are wrongfully calculated into the inpatient claim, which results in a double payment to the hospitals. If there is an overpayment determination, the provider that made the error must go through the lengthy appeals process. Additionally, 42 C.F.R. § 424.535 allows CMS to revoke a provider's Medicare enrollment for many reasons, including abuse of billing privileges, failure to meet documentation requirements, and noncompliance with enrollment requirements.

### Other Billing Issues

There are two main billing issues that providers often find challenging. First are the slight billing differences between hospitals and hospitals' wholly owned or wholly operated Part B entities. Second, six common areas of the rule are often misunderstood by qualifying providers, also leading to incorrect billing practices. These include:

1. Understanding what clinically related services are;
2. Knowing which services are "non-diagnostic";
3. Knowing the definition of "diagnostic";
4. Understanding how critical access hospitals (CAHs) are affected;
5. Knowing when the 3-day payment window actually begins; and
6. Understanding what a "wholly owned or wholly operated entity" is.