

3 Day Rule: Outpatient Stay Prior to Inpatient Admission

*all red text is new for 11/16/2015

In anticipation of or in preparation for Hospital Modernization and payment based on APCs, the Department of Social Services (DSS) is implementing the 3 day rule (2 days plus the admission date) in a post and pay status to give hospitals the opportunity to adjust to the new edits that will be effective with Ambulatory Payment Classification (APC) implementation.

Effective for admissions on or after November 1, 2015, outpatient services provided within 3 days of the hospital admission, provided by the hospital or an entity wholly owned or wholly operated by the hospital, must be billed on an inpatient claim. Explanation of Benefits (EOB) code 5077 "Inpatient stay denied due to a paid outpatient claim within 3 days prior to inpatient admission" or EOB code 5078 "Outpatient claim denied due to a paid inpatient claim within 3 days after an outpatient claim" are initially set up in a post and pay status. The post and pay status means the edit will be displayed on the claim but the claim will not be denied for that reason. The EOB code will post to the hospital's Remittance Advice (RA).

Maintenance renal dialysis services, physical therapy, occupational therapy, speech therapy, audiology services, Intensive Outpatient Services (IOP), Partial Hospital Program (PHP), Electroshock Treatment (ECT), Extended Day Treatment (EDT) and psychotherapy services (individual therapy, group therapy and family therapy) and psychological testing are excluded from this requirement and will be allowed to continue to be billed on an outpatient claim, regardless of a subsequent inpatient admission. Outpatient services provided within 3 days of the hospital admission, that are deemed unrelated to the admission, may continue to be billed on a separate outpatient claim. Hospitals should bill with Condition Code 51 "Attestation of Unrelated Outpatient Non-diagnostic Services" to identify those services that are unrelated and for which separate outpatient reimbursement is appropriate.

For any admissions on or after March 1, 2016, the hospitals are required to bill all related outpatient services within 3 days prior to inpatient admission on the inpatient claims. Once the post and pay period ends on March 1, 2016, the outpatient or inpatient claim will begin to deny payment with either EOB code 5077 or 5078.

3 Day Rule: Outpatient Stay Prior to Inpatient Admission FAQ

1. What services are identified as maintenance renal dialysis services?
 - A. Maintenance renal dialysis services are identified by revenue codes 082X, 083X, 084X and 085X.
2. What services are identified as physical therapy, occupational therapy, speech therapy and audiology services?
 - A. Physical therapy, occupational therapy, speech therapy and audiology services are identified by revenue codes 42X, 43X, 44X and 47X.
3. What services are identified as behavioral health services??

- A. Behavioral Health services are identified by ECT RCC 901, IOP RCCs 905-906, Extended Day Treatment RCC 907, PHP RCC 913 and psychotherapy services RCCs 914-916.
4. If the hospital bills for outpatient services prior to an inpatient bill, how will the claim process?
 - A. If an outpatient claim is submitted prior to the inpatient bill, the outpatient claim will process as it does today. When the inpatient claim is later submitted, the inpatient claim will post EOB code 5077. Conversely, if the inpatient claim processes first, the subsequent outpatient claim will post EOB code 5078. Refer to billing examples scenario 1 and 2 below.
 5. Why is the post and pay status being used for the 3 Day Rule?
 - A. The post and pay status allows hospitals to monitor claims that will start denying for admissions on or after March 1, 2016 if the outpatient claim is billed separately and not with the inpatient stay. The post and pay means the EOB will be shown on the claim but the claim is not denied for that reason.
 6. Will the EOB codes show up on hospital's Remittance Advice (RA)?
 - A. Yes, the EOB codes will post on the hospital's PDF RA. It will not post to the 835 X12 Electronic Remittance Advice (ERA).
 7. What other outpatient services are deemed unrelated to the 3-day rule except those already excluded?
 - A. If the hospital deems the outpatient claim to be unrelated to an inpatient admission, it should bill with condition code 51 on the outpatient claim.

Billing examples

Scenario #1 - Outpatient claim submitted prior to inpatient claim.

Claim Detail	DOS	RCC	Procedure code	Amount Billed	Amount Paid	EOB Code
Claim 1 - Outpatient	11/1/15	450	99283	500.00	156.82	
Claim 2 - Inpatient	11/3/15	121		1500.00	DRG allowance	5077

If a hospital submits the outpatient claim prior to the inpatient bill being submitted, the outpatient claim will continue to process as it does today. When the same hospital bills the inpatient claim, it will post and pay with EOB code 5077.

Scenario #2 - Inpatient claim submitted prior to outpatient claim.

Claim Detail	DOS	RCC	Procedure code	Amount Billed	Amount Paid	EOB Code
Claim 1 - Inpatient	11/3/15	121		1500.00	DRG Allowance	
Claim 2 - Outpatient	11/1/15	450	99283	500.00	156.82	5078

If a hospital submits the inpatient claim prior to the outpatient bill being submitted, the inpatient claim will continue to process as it does today. When the hospital bills the outpatient claim, it will post and pay with EOB code 5078.