Reimbursement Policy

Outpatient Hospital Services Preceding an Inpatient Admission

REIMBURSEMENT POLICY NUMBER: 6

Effective Date: 2/1/2026

Last Review Date: 1/2026

Next Annual Review: 1/2027

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

☐ Professional Claims ☐ DMEPOS Suppliers

Both non-participating and Plan participating and contracted facilities reimbursed on any of the following payment methodologies:

☒ DRG ☒ Modified DRG

Plan Product:

☒ Commercial
☒ Medicare
☐ Medicaid/Oregon Health Plan (OHP)

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

☒ Percentage of billed charges/per diem

POLICY STATEMENT

NOTE:

- Provider contract language applies and may vary.
- This policy does **not** apply to *Facility Routine Supplies and Services*, which are addressed in a separate reimbursement policy (see Cross References below).

I. The Company uses the Centers for Medicare & Medicaid Services (CMS) "3-day (or 1-day) Payment Window" provision for preadmission diagnostic and nondiagnostic outpatient services when determining reimbursement for outpatient diagnostic and nondiagnostic services preceding an inpatient admission. However, this 3-day (or 1-day) payment window **does not apply** to:

A. Critical access hospitals (CAH).
B. Outpatient diagnostic services included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate.

NOTE: To determine if the preadmission bundling provision for a hospital type should be a 3-day or a 1-day payment window, see Policy Guidelines below.

Outpatient Diagnostic Services (Including Clinical Diagnostic Laboratory Tests)

II. All outpatient diagnostic services provided up to three calendar days (or 1-day) before **and** on the date of the inpatient admission are included on the inpatient claim, but are considered **not separately reimbursable** and are bundled into the inpatient claim payment.

III. All outpatient diagnostic services furnished **more than** 3 days (or 1-day) preceding the date of admission to the hospital are not bundled on the inpatient bill with other outpatient services that were furnished. Instead, outpatient diagnostic services that were furnished **prior to** the span of the payment window should be billed separately. (This is true even when all of the outpatient services were furnished during a single, continuous outpatient encounter.)

Outpatient Non-Diagnostic Services (Except Ambulance and Maintenance Renal Dialysis Services)

IV. Outpatient non-diagnostic services *related to* the inpatient admission (except ambulance and maintenance renal dialysis services) when provided up to 3-days (or 1-day) preceding the date of inpatient admission or on the date of the inpatient admission are considered **not separately reimbursable** and bundled into the facility inpatient payment. Examples of non-diagnostic services include, but may not be limited to, the following (A-D):

A. Emergency Department (ED) or Emergency Room (ER) services.
B. Observation services.
C. Surgical procedures.
D. Recovery room.

V. All outpatient non-diagnostic services which are *unrelated to* the inpatient admission (meaning they are clinically distinct or independent from the reason for the admission) may be considered **separately reimbursable** and are not bundled into the facility inpatient payment. These should be submitted on a separate outpatient hospital claim.

VI. All related outpatient non-diagnostic services furnished *prior to the* 3 day/1-day payment window of the inpatient admission may be considered **separately reimbursable** and are not bundled into the facility inpatient payment. These should also be submitted on a separate outpatient hospital claim.

POLICY GUIDELINES

BACKGROUND

Outpatient Hospital Services Rendered Prior to an Inpatient Admission

"When a patient is treated as an outpatient prior to admission as an inpatient in the same facility, the provisions for billing the outpatient services depend on the type of facility and the types of services provided."[1] Some facility types are subject to a 3-day payment window, while others are subject to a 1-day payment window, and still others are not subject to the CMS preadmission bundling provisions at all.

Payment Windows

Inpatient Prospective Payment System (IPPS) Hospitals

Facilities paid under the Inpatient Prospective Payment System (IPPS) must include all outpatient diagnostic and admission-related non-diagnostic services provided up to three calendar days preceding the date of admission as an inpatient admission.[1]

For example, if a patient is admitted on a Wednesday, then the outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

All services – except for ambulance and maintenance renal dialysis services – that are provided during this 3-day bundling window are deemed related to the admission and are not separately billable, **unless the hospital attests otherwise**. In this latter scenario, condition code 51, "Attestation of Unrelated Outpatient Non-diagnostic Services" would be used to indicate the non-diagnostic services are clinically

distinct or independent from the reason for the admission in order to bill them separate from the inpatient claim for reimbursement.[1]

Inpatient Rehabilitation Facilities, Inpatient Psychiatric Facilities, Long Term Care Hospitals

Hospitals excluded from IPPS are subject to the same preadmission bundling provisions as IPPS facilities; however, instead of applying a **3**-day payment window, they are subject to a **1**-day payment window. This 1-day payment window includes services provided the day of and the day before the inpatient admission.[1] Note, these facilities may also be referred to as "Non-subsection (d) hospitals."[2] A non-subsection (d) hospital is, a hospital **not** paid under the IPPS. These include, but may not be limited to, psychiatric hospitals, inpatient rehabilitation hospitals, long-term care hospitals, children's hospitals, and cancer hospitals.

Critical Access Hospitals

Critical Access Hospital is a designation given to eligible rural hospitals by the Centers for Medicare & Medicaid Services (CMS). They are generally smaller in size (25 or less acute care inpatient beds), are located farther away from other hospitals (usually >35 miles, but some exceptions may apply), and maintain an annual average length of stay of 96 hours, while still providing 24/7 emergency care services.[3]

CAHs are not typically subject to the same preadmission bundling provisions detailed above. Instead, all outpatient services provided up to the time of a physician order for admission are to be billed as outpatient services separate from the inpatient claim, even if the inpatient admission order is made during the same encounter.[1]

DEFINITIONS

Non-subsection (d) hospitals: These include Psychiatric hospitals and units; Inpatient Rehabilitation Facilities (IRFs) and units; Long-term care hospitals (LTCHs); Children's hospitals; Cancer hospitals; and the U.S. unincorporated territories' hospitals of American Samoa, Guam and the Northern Mariana Islands.[2,4]

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 12/8/2025, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses outpatient services prior to an inpatient hospital admission:

- Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, §40.3 - Outpatient Services Treated as Inpatient Services, Subsections B and D.
- Noridian web page for 3-Day Payment Window.
- Social Security Act Section 1886 (d)(1)(B). Defines "non-subsection (d) hospitals."
- Noridian web page for ACM Part A Questions and Answers - August 30, 2023.
- MLN Matters SE20024. FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients.

- Noridian web page for ACT Questions and Answers - September 28, 2022.
- Noridian web page for Outpatient to Inpatient Status Change.
- Centers for Medicare and Medicaid Services web page for Critical Access Hospitals.

The above criteria and reimbursement methodologies are consistent with the CMS guidance regarding outpatient services rendered by a hospital prior to an inpatient admission.

BILLING AND CODING GUIDELINES

SUMMARY

Hospitals must include on the claim for an inpatient stay the diagnoses, procedures, and charges for all preadmission outpatient *diagnostic* services and all preadmission outpatient *nondiagnostic* services that meet the below requirements.

Outpatient Diagnostic Services[5]

Outpatient diagnostic services (including clinical laboratory diagnostic tests) are included in the inpatient payment when provided:

- By the admitting hospital, or entity wholly owned or wholly operated by admitting hospital (or another entity under arrangements with admitting hospital), **and**
- Within 3-days (or 1-day) prior to and/or on the admission date.

Outpatient diagnostic services furnished **more than 3 days** preceding the date of admission to the hospital, by law, are not part of the payment window and must not be bundled on the inpatient bill with other outpatient services that were furnished during the span of the 3-day (or 1-day) payment window, even when all of the outpatient services were furnished during a single, continuous outpatient encounter. Instead, outpatient diagnostic services that were furnished **prior to** the span of the payment window should be billed on a separate outpatient services claim.

CMS defines diagnostic services by the presence of revenue and/or CPT codes seen in Table 1.

Table 1: Diagnostic revenue codes include the following:

Diagnostic Revenue Codes	
Code	**Description**
0254	Drugs incident to other diagnostic services
0255	Drugs incident to radiology
030X	Laboratory
031X	Laboratory pathological
032X	Radiology diagnostic
0341, 0343	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals
035X	CT scan
0371	Anesthesia incident to Radiology
0372	Anesthesia incident to other diagnostic services

040X	Other imaging services
046X	Pulmonary function
0471	Audiology diagnostic
0481, 0489	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275, and G0278 diagnostic
0482	Cardiology, Stress Test
0483	Cardiology, Echocardiology
053X	Osteopathic services
061X	MRT
062X	Medical/surgical supplies, incident to radiology or other diagnostic services
073X	EKG/ECG
074X	EEG
0918	Testing- Behavioral Health
092X	Other diagnostic services

The following instruction is from the Noridian Jurisdiction F (J-F) website:

> ***Q1: When a single patient encounter begins greater than 3 calendar days prior to an inpatient admission, how are the outpatient charges incurred more than 3 days prior to the inpatient admission to be billed? We understand all charges, diagnostic and non-diagnostic, for the 3 calendar days preceding the inpatient admission must be bundled into the inpatient bill, as they are related and so included in the payment window, but what about the outpatient services provided greater than 3 days prior to inpatient admission? Would those outpatient services outside the payment window be separately billed as outpatient, even though all services were provided during a single continuous encounter?***
> *A1: The outpatient charges are incurred on a 13X TOB. All outpatient services provided prior to the payment window are billed as outpatient services. The services would be separately billed as outpatient even though all the services were provided during a single continuous encounter.*[6]
>
> ***Q5: What is the appropriate way to bill COVID-19 vaccines given by hospital staff within the 3-day payment window of an inpatient stay? We understand that it may be billed separately and receive separate reimbursement even if it was combined with the IP claim.***
> *A5: There are two scenarios to be considered:*
>
> 1. ***Related to inpatient admission:*** *If the outpatient non-diagnostic service (the COVID-19 vaccine) is clinically associated with the reason for inpatient admission, then it is subject to bundling, and the non-diagnostic service is reported on an inpatient claim (TOB 11X) with the appropriate condition code A6 and diagnosis code Z23.*
> 2. ***Unrelated to inpatient admission:*** *If the hospital determines the non-diagnostic preadmission service is NOT clinically related to the inpatient admission, then it is NOT subject to the 3-day payment window policy. Hence, the hospital must bill on an outpatient claim TOB 13X, with condition code 51 (as an attestation of unrelated OP non-diagnostic service).*[7,8]

Outpatient Non-Diagnostic Services[9]

All outpatient nondiagnostic services – except for ambulance and maintenance renal dialysis services – that are provided by the hospital (or an entity wholly owned or wholly operated by the hospital) **on the date of an inpatient admission** are deemed related to the admission, and thus, must be billed with the inpatient stay.

Outpatient nondiagnostic services – except for ambulance and maintenance renal dialysis services – that are provided by the hospital (or an entity wholly owned or wholly operated by the hospital) up to 3 calendar days preceding the date of an inpatient admission are deemed related to the admission and must be billed with the inpatient stay.

However, the hospital may attest to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the admission) by adding a condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") to a separately billed outpatient nondiagnostic services claim.

Both Diagnostic and Non-Diagnostic Services

If there are both diagnostic and nondiagnostic preadmission services and the nondiagnostic services are unrelated to the admission, the hospital may separately bill the *nondiagnostic* preadmission services.

All *diagnostic* services must be included on the inpatient hospital claim when rendered with in the 3-day (or 1-day) window.

CROSS REFERENCES

- Facility Routine Supplies and Services, RP43

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Noridian web page. *Outpatient to Inpatient Status Change*. Updated 9/2025. https://med.noridianmedicare.com/web/jfa/topics/observation/outpatient-to-inpatient-status-change. Accessed 12/8/2025.
2. Noridian web page. *3-Day Payment Window*. Updated 6/2025. https://med.noridianmedicare.com/web/jfa/topics/claim-submission/3-day-payment-window. Accessed 12/8/2025.
3. Centers for Medicare and Medicaid Services (CMS). Critical Access Hospitals. Updated 12/2024. https://www.cms.gov/medicare/health-safety-standards/certification-compliance/critical-access-hospitals. Accessed 12/8/2025.
4. Social Security Act Section 1886 (d)(1)(B). Defines "non-subsection (d) hospitals"
5. CMS. Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, § §40.3 - Outpatient Services Treated as Inpatient Services, B. - Preadmission Diagnostic Services

(Effective for Services Furnished On or After January 1, 1991). Updated 2014; https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c03.pdf. Accessed 12/8/2025.
6. Archived Noridian web page. *ACT Questions and Answers - September 28, 2022*. 11/7/2023. https://med.noridianmedicare.com/web/jfa/search-result/-/view/10529/act-questions-and-answers-september-28-2022. Accessed 3/10/2025.
7. Archived Noridian web page. *ACM Part A Questions and Answers - August 30, 2023*. Last Updated: 4/11/2024. https://med.noridianmedicare.com/web/jfa/article-detail/-/view/10529/acm-part-a-questions-and-answers-august-30-2023. Accessed 3/10/2025.
8. MLN Matters SE20024. FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients. Updated 12/2020. https://www.cms.gov/files/document/se20024.pdf. Accessed 12/8/2025.
9. CMS. Medicare Claims Processing Manual, Chapter 3—Inpatient Hospital Billing, § 40.3 - Outpatient Services Treated as Inpatient Services, D. - Other Preadmission Services (Effective for Services Furnished On or After June 25, 2010). Updated 2014; https://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c03.pdf. Accessed 12/8/2025.
10. CMS. Three Day Payment Window. Updated 9/2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/three-day-payment-window. Accessed 12/8/2025.

POLICY REVISION HISTORY

Date	Revision Summary
7/2024	New reimbursement policy
5/2025	Annual review, format changes only
2/2026	Annual review, update title and references