



SKILLED NURSING FACILITY 3-DAY RULE BILLING



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Learn about and how to apply the 3-day rule:

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- Communicating Medicare SNF Services Coverage Rules
- Medicare SNF Claims Processing
- Financial Responsibility for SNF Services When There is No 3-Day Qualifying Inpatient Stay
- Resources

BACKGROUND

To qualify for Skilled Nursing Facility (SNF) extended care services coverage, Medicare beneficiaries must meet the “3-day rule” before SNF admission. The 3-day rule requires the beneficiary to have a medically necessary 3-day-consecutive inpatient hospital stay and does not include the day of discharge, or any pre-admission time spent in the emergency room (ER) or in outpatient observation, in the 3-day count.

SNF extended care services are an extension of care a beneficiary needs after hospital discharge or within 30 days of their hospital stay (unless admitting them within 30 days is medically inappropriate). Hospitals should correctly communicate to SNFs and beneficiaries (and/or their representatives) the number of inpatient days, so all parties fully understand the potential payment liability.

The law at [§1861\(i\) of the Social Security Act](#) and the implementing regulations in [Title 42 of the Code of Federal Regulations \(CFR\) § 409.30](#) specify that for Medicare to cover SNF services, the beneficiary must first have a qualifying inpatient stay in the hospital of at least **3 consecutive calendar days**, starting with the calendar day of hospital admission but not counting the day of discharge.

- Improper Medicare payments may occur when a hospital discharges an inpatient Medicare beneficiary before the patient meets the 3-day rule, and the SNF admits the patient for extended care services.
 - Hospitals must correctly understand the 3-day rule, so they give accurate inpatient stay information dates to SNFs and beneficiaries
 - SNFs must correctly understand the 3-day rule to avoid inappropriately submitting claims that **do not** meet the 3-day rule

3-DAY PRIOR HOSPITALIZATION BEFORE SNF ADMISSION

Medicare beneficiaries meet the 3-day rule by staying **3 consecutive days** in one or more hospitals as an inpatient. Hospitals **count the admission day but not the discharge day**. Time spent in the ER or in outpatient observation prior to admission **does not** count toward the 3-day rule.

3-DAY RULE WAIVER

There are certain [Shared Savings Program](#) (SSP) Tracks and Center for Medicare & Medicaid Innovation Models, including, but not limited to, the [Next Generation ACO Model](#), the [Comprehensive Care for Joint Replacement Model](#), and the [Bundled Payments for Care Improvement Advanced Model](#), that offer SNF services without a prior 3-day inpatient hospitalization when an eligible beneficiary is referred and admitted to a SNF that has been approved by CMS to use the waiver.

COMMUNICATING MEDICARE SNF SERVICES COVERAGE RULES

To help SNFs make informed decisions about Medicare-eligible inpatient claims billing and reimbursement, hospitals should give SNFs and beneficiaries (and/or their representatives) accurate inpatient hospital stay information. Facilities can use the [Medicare Outpatient Observation Notice](#) (MOON), the [Important Message From Medicare](#) (IM), and the [Are You a Hospital Inpatient or Outpatient?](#) documents to share information.

Figure 1 describes the relationship between observation services and the 3-day rule; the effect observation services may have on eligibility for extended care services; hospitals correctly communicating to a beneficiary (and/or their representative) about observation services and SNF admission; and what type of claim, if any, to submit to Medicare.

Figure 1. Using the MOON

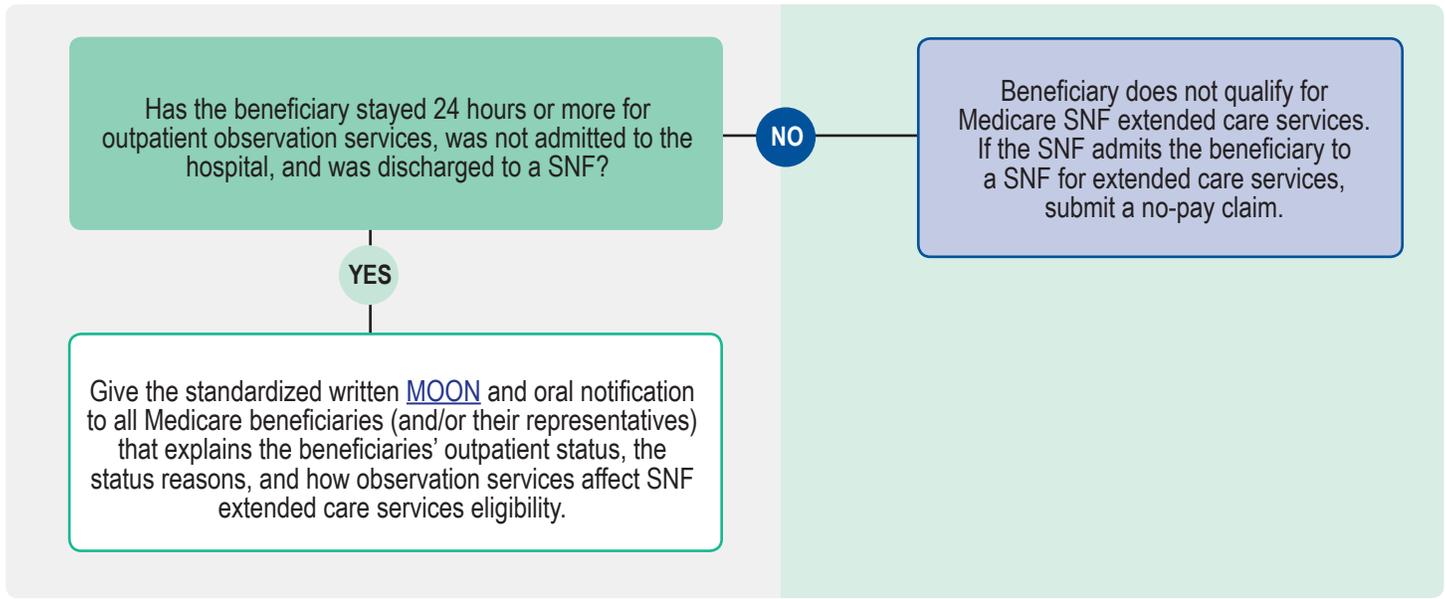
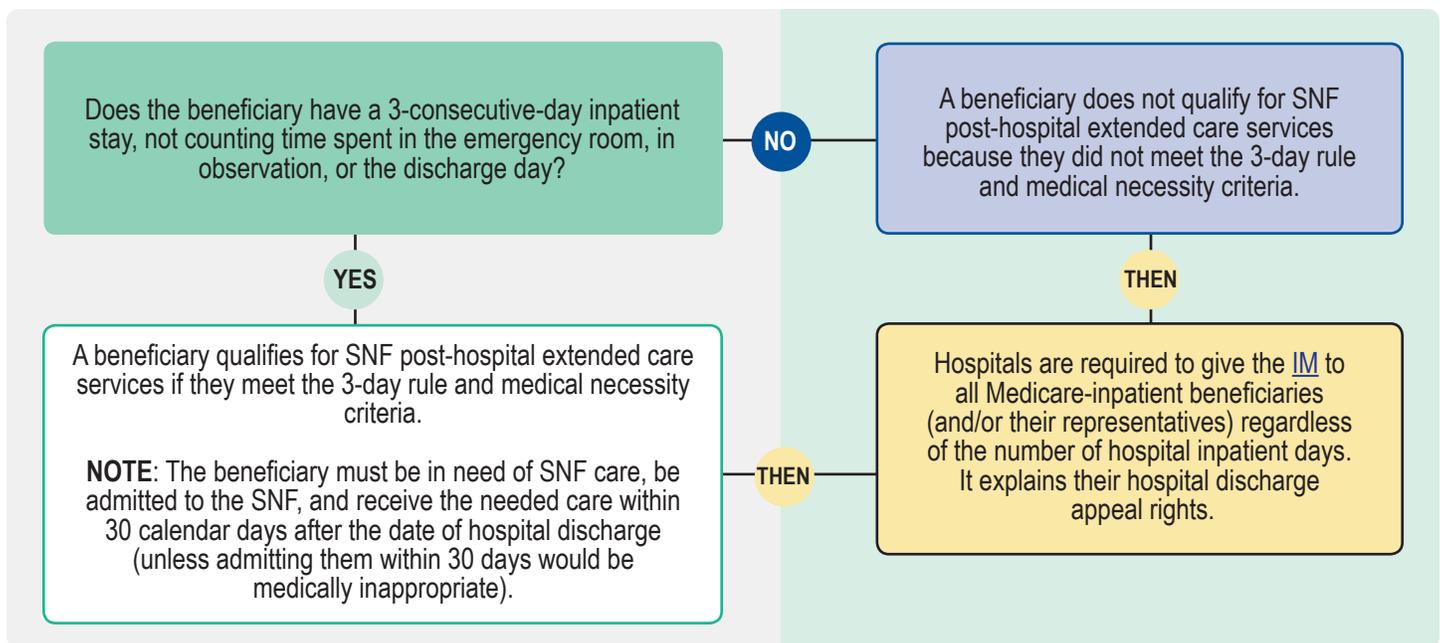


Figure 2 describes the relationship between hospitalization and skilled care, hospitalization and the benefit period, and correctly communicating beneficiary appeal rights.

Figure 2. Using the IM



MEDICARE SNF CLAIMS PROCESSING

Medicare has claims processing edits to verify SNF claims meet the 3-day rule. Specifically:

- SNFs must report occurrence span code “70” when providing the dates of a qualifying hospital stay of at least 3 consecutive calendar days, not counting the date of discharge
- Medicare rejects a SNF claim if it includes an inpatient hospital stay less than 3 consecutive calendar days, not counting the date of discharge
- Medicare rejects a SNF claim if at least one of the dates reported with occurrence span code “70” matches an incoming or previously posted inpatient hospital’s claim dates of service found within 30 days of the SNF admission, and **the hospital stay dates do not span 3 or more calendar days**, not including the date of discharge
- Medicare allows the SNF or hospital claim payment, if they meet certain bypass criteria

Inpatient Hospital Stay Days, SNF, and Hospital (Example)

Hospitals should clearly communicate to the beneficiary (and/or their representative) and the SNF the number of inpatient days stayed in the hospital, if the patient is discharging to a SNF for extended care services. The SNF should verify the beneficiary’s hospital stay during SNF admission to ensure the patient met the 3-day rule.

A beneficiary went to a hospital emergency room (ER) after falling in her home and a physician admitted her to the hospital on April 16. On April 18, the hospital discharged her to SNF extended care services. In this case, the beneficiary did not stay in the hospital long enough to satisfy the 3-day rule. Hospitals can count the admission day (April 16), but not the discharge day (April 18).

SNF staff gave the beneficiary and their representative an IM and proactively told the beneficiary and her representative she does not qualify for SNF coverage because she did not stay in the hospital 3 days not counting discharge. Medicare rules allow SNF stay coverage when the beneficiary’s hospital stay meets the 3-day rule. Since the beneficiary’s inpatient stay was 2 days, if she accepts the SNF admission, she must pay the extended care services claim out-of-pocket unless she has other coverage.

Inpatient and Non-Inpatient Hospital Stay Days and SNF Claims Reporting (Example)

A beneficiary went to a hospital ER for treatment on April 21. On April 22, the physician admitted him to the hospital. On April 24, the physician discharged him for SNF extended care services. The hospital claim incorrectly reported the inpatient stay as 3 days.

The inpatient stay was only 2 days, because the hospital cannot count the day of discharge or the pre-admission time that the beneficiary spent in the ER. The associated SNF claim **incorrectly** reported the qualifying inpatient dates in occurrence span code “70” as April 21 through April 24, which inaccurately showed the hospital stay met the 3-day rule. This caused the SNF services claim payment in error. If the SNF is considered “at fault” for the improper payment, it becomes liable to return the overpayment to CMS within 60 days of identifying the overpayment error.

FINANCIAL RESPONSIBILITY FOR SNF SERVICES WHEN THERE IS NO 3-DAY QUALIFYING INPATIENT STAY

Medicare **will not** pay for extended care services in a SNF when coverage is denied because there was no 3-day qualifying hospital inpatient stay. While Medicare rules limit beneficiary financial liability for certain denials, these protections do not apply when extended care services are not covered due to the lack of a qualifying inpatient stay.

- If there is no 3-day qualifying hospital inpatient stay (that is, the 3-day rule for SNF coverage is not met), Medicare **does not** require the SNF to issue a SNF Advance Beneficiary Notice of Non-coverage (SNF ABN) in order to charge the beneficiary for non-covered care. However, we strongly encourage SNFs to do so, because the SNF does not expect Medicare payment and the patient (and/or the patient's representative) should fully understand the patient's liability for the cost of the stay. For more information on the SNF ABN and the purpose of this form, please visit the [SNF ABN webpage](#).

In situations where a Medicare contractor made an improper payment for extended care services to a SNF where the beneficiary did not have a qualifying inpatient stay, the contractor may assess an overpayment and recover the improper payment. Before recovering the overpayment, the Medicare contractor **must** determine whether or not the provider or beneficiary was without fault with respect to the overpayment under [§1870 of the Social Security Act](#).

- If it is determined that the **provider is not without fault for the overpayment** (for example, it did not exercise reasonable care in billing and knew or should have known it would be overpaid), then the contractor recovers the overpayment from the SNF.
- If it is determined that the **provider is without fault**, Medicare waives recovery of the overpayment with respect to the provider and considers it a beneficiary overpayment.
- If it is determined that the **beneficiary is not without fault for the overpayment**, then Medicare recovers the overpayment from the beneficiary. However, if recovery would cause the beneficiary financial hardship or would be against equity and good conscience then Medicare may waive recovery from the beneficiary ([§1870\(c\) of the Social Security Act](#)).
- If both the **provider and beneficiary are determined to be without fault for the overpayment**, CMS would bear the cost of non-covered SNF care.



RESOURCES

Table 1. Resource Table

Resource	Website
42 CFR § 411.400	eCFR.gov/cgi-bin/text-idx?SID=81dae6010aa386b769c7e7313f1924d2&node=se42.2.411_1400&rgn=div8
Are You a Hospital Inpatient or Outpatient?	Medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf
CMS Improperly Paid Millions of Dollars for Skilled Nursing Facility Services When the Medicare 3-Day Inpatient Hospital Stay Requirement Was Not Met	OIG.HHS.gov/oas/reports/region5/51600043.asp
Important Message from Medicare	CMS.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html
Medicare Claims Processing Manual, Chapter 8	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c08.pdf
Medicare Claims Processing Manual, Chapter 6	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf
Medicare Claims Processing Manual, Chapter 30	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf
Medicare Financial Management Manual, Chapter 3, 70.3(C), 90, 100	CMS.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/fin106c03.pdf
Medicare Outpatient Observation Notice (MOON)	CMS.gov/Medicare/Medicare-General-Information/BNI/MOON.html
MLN Matters® Special Edition Article, SE0403, Reminder of the Required Three-day Hospital Stay for SNF Admissions	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0403.pdf
Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN)	CMS.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN-.html
SNF Billing Reference	CMS.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1244978.html

Table 2. Hyperlink Table

Embedded Hyperlink	Complete URL
§1861(i) of the Social Security Act	https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
§1870 of the Social Security Act §1870(c) of the Social Security Act	https://www.ssa.gov/OP_Home/ssact/title18/1870.htm
Are You a Hospital Inpatient or Outpatient?	https://www.medicare.gov/Pubs/pdf/11435-Are-You-an-Inpatient-or-Outpatient.pdf
Bundled Payments for Care Improvement Advanced Model	https://innovation.cms.gov/initiatives/bpci-advanced
Comprehensive Care for Joint Replacement Model	https://innovation.cms.gov/initiatives/cjr
Important Message From Medicare (IM)	https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html
Medicare Outpatient Observation Notice (MOON)	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html
Next Generation ACO Model	https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/nextgenaco-fnclalgnfaqs.html
Shared Savings Program	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram
SNF ABN Webpage	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNFABN-.html
Title 42 of the Code of Federal Regulations (CFR) § 409.30	https://www.ecfr.gov/cgi-bin/text-idx?SID=db85d7cbc7b28cb756e2abcae3138bb3&mc=true&node=pt42.2.409&rgn=div5#se42.2.409_130

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