

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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MEMORANDUM

Date: August 9, 2010

IMPORTANT NOTICE TO ALL MEDICARE PROVIDERS

Implementation of New Statutory Provision Pertaining to Medicare 3-Day Payment Window – Outpatient Services Treated as Inpatient

On June 25, 2010, President Obama signed into law the “Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010,” Pub. L. 111-192. Section 102 of the law pertains to Medicare’s policy for payment of outpatient services provided on either the date of a beneficiary’s admission or during the three calendar days immediately preceding the date of a beneficiary’s inpatient admission to a “subsection (d) hospital” subject to the inpatient prospective payment system, “IPPS” (or during the one calendar day immediately preceding the date of a beneficiary’s inpatient admission to a non-subsection (d) hospital). This policy is known as the “3-day (or 1-day) payment window.” Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary’s inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services that are furnished to the beneficiary during the 3-day (or 1day) payment window. The new law makes the policy pertaining to admission-related outpatient nondiagnostic services more consistent with common hospital billing practices. Section 102 of Pub. L. 111-192 is effective for services furnished on or after the date of enactment, June 25, 2010.

This memorandum serves as notification of the implementation of the 3-day (or 1-day) payment window provision under section 102 of Pub. L. 111-192 and includes general instructions on appropriate billing for compliance with the law. CMS will provide conforming updates to the Medicare regulations and the Medicare Claims Processing Manual (Pub 100-4) in the near future.

Background on the 3-Day Payment Window Policy

Section 1886(a)(4) of the Act, as amended by the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990, Pub. L. 101-508), defines the operating costs of inpatient hospital services to include certain outpatient services furnished prior to an inpatient admission. Specifically, the statute requires that the operating costs of inpatient hospital services include diagnostic services (including clinical diagnostic laboratory tests) or other services related to the admission (as defined by the Secretary) furnished by the hospital (or by an entity that is wholly owned or wholly operated by the hospital) to the patient during the 3 days preceding the date of the patient's admission to a subsection (d) hospital subject to the IPPS. For a non-subsection (d) hospital (that is, a hospital not paid under the IPPS: psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children's hospitals, and cancer hospitals), the statutory payment window is 1 day preceding the date of the patient's admission.

While OBRA 1990 expanded upon CMS's longstanding administrative policy requiring outpatient services furnished on the same day of a beneficiary's inpatient admission to be billed as inpatient services, the law also distinguished the circumstances for billing outpatient "diagnostic services" from "other (nondiagnostic) services" as inpatient hospital services. Under the 3-day (or 1-day) payment window policy, all outpatient diagnostic services furnished to a Medicare beneficiary by a hospital (or an entity wholly owned or operated by the hospital), on the date of a beneficiary's admission or during the 3 days (1 day for a non-subsection (d) hospital) immediately preceding the date of a beneficiary's inpatient hospital admission, must be included on the Part A bill for the beneficiary's inpatient stay at the hospital; however, outpatient nondiagnostic services provided during the payment window are to be included on the bill for the beneficiary's inpatient stay at the hospital *only when* the services are "related" to the beneficiary's admission.

The 3-day and 1 day payment window policy respectively is currently codified at 42 CFR 412.2(c)(5) for subsection (d) hospitals and 413.40(c)(2) for non-subsection (d) hospitals, with detailed policy guidance included in the Medicare Claims Processing Manual (Pub. 100-4), Chapter 3, section 40.3, "*Outpatient Services Treated as Inpatient Services.*" The regulations at §412.2(c)(5) and §413.40(c)(2) provide that a hospital is considered the sole (whole) operator of an entity if the hospital has exclusive responsibility for conducting or overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. Additionally, the regulations specify that ambulance and chronic maintenance renal dialysis services are excluded from preadmission services subject to the payment window. Through public notice and comment period rulemaking, CMS defined "services related to the admission" as those nondiagnostic services that are furnished in connection with the principal diagnosis assigned to the inpatient admission that requires the beneficiary to be admitted as an inpatient (59 FR 1654, January 12, 1994) and established that the term "day", for purposes of the payment window, refers to the entire calendar day immediately preceding the date of admission, not the 24-hour time period that immediately precedes the hour of admission (60 FR 45840, September 1, 1995). The policy guidance in Pub. 100-4 also

clarifies that the payment window applies to outpatient services that are otherwise billable under Part B and does not apply to nonhospital services that are generally covered under Part A (such as home health, skilled nursing facility, and hospice) and critical access hospitals.

Requirements of Section 102

The new statute clarifies that the term in section 1886(a)(4) of the Act, “*other services related to the admission*” includes all outpatient services that are not diagnostic services (and are not ambulance and maintenance renal dialysis services), provided to a Medicare beneficiary by a hospital (or an entity wholly owned or wholly operated by the hospital):

- (1) on the date of the beneficiary’s inpatient admission, or,
- (2) during the 3 days (or in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of admission unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission.

The statute makes no changes to the existing policy regarding billing of *diagnostic services* (see section 40.3(B) of Pub100-4, Chapter 3). All diagnostic services provided to a Medicare beneficiary by a hospital (or an entity wholly owned or operated by the hospital) on the date of the beneficiary’s inpatient admission or during the 3 calendar days (or, in the case of a non-subsection (d) hospital, 1 calendar day) immediately preceding the date of admission would continue to be required to be included on the bill for the inpatient stay.

The statute also prohibits Medicare from reopening a claim, adjusting a claim, or making payments pursuant to any request for payment under Title 18, submitted by an entity (including a hospital or an entity wholly owned or operated by the hospital), for services described in section 102(c)(2) of Pub. L. 111-192 for purposes of treating, as unrelated to a patient’s inpatient admission, services provided during the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1 day) immediately preceding the date of the patient’s inpatient admission. Services described in section 102(c)(2) of Pub. L. 111-192 are other services related to the admission which were previously included on a claim or request for payment submitted under part A of Title 18 for which a reopening, adjustment, or request for payment under part B of Title 18, was not submitted prior to June 25, 2010 for purposes of treating, as unrelated to a patient’s inpatient admission.

Application of Section 102

In accordance with section 1886(a)(4) of the Act, outpatient nondiagnostic services that are related to an inpatient admission must be bundled with the billing for the inpatient stay. An outpatient service is related to the admission if it is clinically associated with the reason for a patient’s inpatient admission. In accordance with section 102 of Pub. L.

111-192, for services furnished on or after June 25, 2010, all outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay. Also, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the IPPS (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay, *unless* the hospital attests 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 beneficiary's admission). Outpatient nondiagnostic services provided during the payment window that are unrelated to the admission, and are covered by Part B, may be separately billed to Part B. The June 25, 2010 effective date of section 102 of Pub. L. 111-192 applies to outpatient services provided on or after June 25, 2010.

CMS intends to establish a process for hospitals to attest to nondiagnostic services as being unrelated to the hospital claim when a hospital submits an outpatient claim. As part of the process, hospitals would be required to maintain documentation in the beneficiary's medical record to support their claim that the preadmission outpatient nondiagnostic services are unrelated to the beneficiary's inpatient admission. We note that hospitals have experience with making similar attestations on the outpatient or inpatient claim. For example, Medicare's current policy when a patient is discharged or transferred from an IPPS hospital, and is readmitted to the same IPPS hospital on the same day for symptoms related to the prior stay, the second stay is bundled into payment for the first stay and not separately paid. However, when a patient is discharged or transferred from an IPPS hospital and is readmitted to the same IPPS hospital on the same day for symptoms unrelated to the prior stay, hospitals can place a condition code (CC) B4 on the inpatient claim that contains an admission date equal to the prior admissions discharge date that would allow the second stay to be paid separately. (See Publication 100-04, Chapter 3, section 40.2.5 for further details of Medicare's policy on this issue). The hospital is using its judgment, based on the patient's medical record, to make the determination that the same day readmission is for symptoms unrelated to the prior stay. If the condition code is not included on the claim for a same day readmission, edits will bundle the claim for the second admission into the first claim and make only one payment for one inpatient discharge. We plan to develop similar edits that bundle claims for all outpatient services provided during the 3-day or 1-day payment window into the payment for the related inpatient admission unless the hospital, for the first, second, and third calendar days (first calendar day for a non-subsection (d) hospital) immediately preceding the date of the beneficiary's inpatient admission, includes a condition code, a modifier, or some other indicator (to be determined in the near future) on the claim attesting that certain outpatient nondiagnostic services are unrelated to the later inpatient admission.

Interim Billing Procedures for 3-day Payment Window

In the near future, CMS expects to update the Medicare regulations and instructions in Pub. 100-4, Chapter 3, section 40.3 to conform to the requirements of section 102. Even before the final regulations, instructions, and process for attesting to certain services as being unrelated are in place, hospitals are required by law to comply with section 102. That is, hospitals must include on a Medicare claim for a beneficiary's inpatient stay the diagnoses, procedures, and charges for all preadmission outpatient diagnostic services and all preadmission outpatient nondiagnostic services that meet the requirements of section 102. For purposes of the Present on Admission Indicator (POA), even if the outpatient services are bundled with the inpatient claim, hospitals shall code any conditions the patient has at the time of the order to admit as an inpatient as POA irrespective of whether or not the patient had the condition at the time of being registered as a hospital outpatient. We note that, in combining on the inpatient bill the diagnoses, procedures, and charges for the outpatient services, a hospital must convert CPT codes to ICD-9-CM codes and must only include outpatient diagnostic and admission-related nondiagnostic services that span the period of the payment window. Outpatient services furnished to a beneficiary more than 3 days (for a non-subsection (d) hospital, more than 1 day) preceding the date of the beneficiary's 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, the outpatient services that were furnished prior to the span of the payment window may be separately billed to Part B.

If a hospital believes that outpatient nondiagnostic services provided during the first, second, and third calendar days (first calendar day for a non-subsection (d) hospital) preceding the date of a beneficiary's inpatient admission are truly unrelated to the inpatient admission, the hospital may separately bill for the service to Part B, provided that the hospital can document, and maintains such documentation as part of the beneficiary's medical record, to support its claim that the service is unrelated to the admission. Such separately billed outpatient preadmission services may be subject to subsequent review by CMS or its representative.

Hospitals may continue to bill Medicare separately for outpatient nondiagnostic services furnished prior to June 25, 2010, provided that: 1) the services are not related to an inpatient stay (determination of "related" for services furnished prior to June 25, 2010 is based on guidance published in the *Federal Register*, volume 63, page 6866, February 11, 1998), 2) such services were not previously included on a Medicare claim, and 3) the claim meets all applicable filing deadlines.

In summary, section 102 clarifies the term "related" outpatient services includes all nondiagnostic services unless the hospital attests that the services are clinically unrelated to the later inpatient stay. While the law's clarification is effective prospectively from June 25, 2010, it also leaves unchanged billing practices for services provided prior to the date of enactment. That is, if a hospital had bundled services that did not meet the prior

definition of related, the Secretary may not reopen or otherwise change such claims so that the hospital may be paid separately for services that would otherwise have been separately payable under Part B.

If you have any questions, please contact Valerie Miller on (410) 786-4535 or Amy Gruber on (410) 786-1542.