



## Medicare Hospital and Chargemaster Version LifePoint Custom

### KEY CONCEPTS OUTLINE Module 4: Medicare Billing Issues

#### I. Outpatient Repetitive Services

##### A. What is a “Repetitive Service”

1. CMS defines repetitive services based on the revenue codes used to bill for the services. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>
  - a. The revenue codes that define repetitive services are listed in the *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2, included in the materials behind the outline.

##### B. Billing for Repetitive Services

##### 1. Separate Monthly Claim

- a. Repetitive services must be billed monthly on a separate claim. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2; *Medicare Claims Processing Manual*, Chapter 4 § 170>

##### 2. Services “in Support” of Repetitive Services

- a. Any items or services needed in the performance of the repetitive service should be reported on the same claim as the repetitive service, regardless of the revenue code those items or services are billed under. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>

Examples of supporting items or services include disposable supplies, drugs or equipment used to furnish the repetitive service.

##### 3. Other Services Provided During the Same Month as Repetitive Services

- a. Other services, except those provided in support of the repetitive services, may not be billed on the same claim as the repetitive services. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>

- i. Occurrence Span Code 74
  - a) When an inpatient stay or non-repetitive outpatient hospital services paid under OPPTS occurs during the same month as repetitive services, occurrence span code 74 and the dates encompassing the inpatient stay or outpatient service must be reported on the repetitive service bill. <See *Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>

### Case Study 1

**Facts:** A patient received cardiac rehab services on March 1, 5, 7 and 9. The patient was then admitted as an inpatient to the hospital on March 11-15 for pancreatitis unrelated to their cardiac condition. The patient returned to cardiac rehab on March 19 and received cardiac rehab services on March 19, 21, 23, 26, 28 and 30. How should the cardiac rehab services be billed?

## II. Outpatient Non-repetitive and Recurring Services

### A. Non-Repetitive Services on Different Dates

1. Multiple non-repetitive services provided on different dates in the same month may be billed on the same claim or separate claims. CMS sometimes refers to these services as “recurring services”. <*Medicare Claims Processing Manual*, Chapter 1 § 50.2.2>

**Caution:** Payment packaging is performed on a per claim basis. Billing services with different dates of service on the same claim may result in unintended packaging of unrelated services.

### B. Non-Repetitive Services on the Same Date

1. Subject to the exceptions noted below, all services and supplies provided on the same day as a separately payable, non-repetitive outpatient service must be reported on the same claim. This will generally result in a single claim for all non-repetitive services provided on the same date of service. <*Medicare Claims Processing Manual*, Chapter 4 § 170>
  - a. MACs have been instructed to return claims with the same date of service to providers unless they are an exact duplicate, which are rejected, or contain condition codes 20, 21 or G0, discussed later in this module. <See Program Memorandum Intermediaries, Transmittal A-00-36, pg. 17; *Medicare Claims Processing Manual*, Chapter 1 § 120.2>

## 2. Exceptions

- a. Exception for services subject to the pre-admission payment window
  - i. Services subject to the one or three-day payment window must be reported on the inpatient claim, even if they are provided on the same date and associated with another non-repetitive outpatient service not subject to the payment window. The three-day payment window will be discussed later in this module. <Medicare Claims Processing Manual, Chapter 4 § 170>
- b. Exception for multiple medical visits:
  - i. Hospitals may report multiple medical visits provided on the same date on the same or separate claims. <Medicare Claims Processing Manual, Chapter 4 § 180.4>
  - ii. Condition Code G0
    - a) Condition code G0 (G zero) is used to report distinct and independent visits billed on the same date in the same revenue center. <See *IOCE Specifications*, Sections 5.1 and 5.1.1 (Supplement); *Medicare Claims Processing Manual*, Chapter 4 § 180.4>

CMS has provided the following examples of distinct and independent visits:

      - A visit to the ER in the morning for a broken arm and in the evening for chest pain
      - Two visits to the ER for chest pain on the same day
    - b) Hospitals must report condition code G0 whether the medical visits are reported on the same or separate claims. <See *IOCE Specifications*, Sections 5.1 and 5.1.1 (Supplement)>
      - 1) If the visits are billed on separate claims, the G0 should be reported on the second claim. <Medicare Claims Processing Manual, Chapter 4 § 180.4>

iii. Modifier -27

- a) Modifier -27, “Multiple Outpatient Hospital E/M Encounters on the Same Date,” is reported for “separate and distinct” medical visits provided on the same date. <Program Memorandum A-01-80>

TIP: Modifier 27 is an NCCI modifier and may be used to override NCCI edits applicable to E/M codes. CMS has not provided a definition of “separate and distinct”, however, they refer to modifier 27 in conjunction with condition code -G0 indicating the definition for “distinct and independent” may apply.

iv. Condition Code -G0 with Modifier -27

- a) Condition Code -G0 must be applied, in addition to modifier -27, if the multiple medical visits occur in the same revenue center. <Program Memorandum A-01-80>

**Case Study 2**

**Facts:** A Medicare patient receiving chemotherapy treatments is registered as a “series” patient at the hospitals’ Cancer Center. The patient received chemotherapy treatments on November 1, 6, 11 and 18. On November 6, the patient is registered as an outpatient at the provider-based clinic where they see their family practitioner related to the flu. The visit was coded with E/M code G0463. Would it be permissible to bill the clinic visit separately from the chemotherapy treatments?

III. Preadmission (Three-Day) Payment Window

- A. Certain outpatient services provided prior to an inpatient admission are considered to be covered costs of the inpatient admission and are billed on the inpatient claim. <See 42 C.F.R. 412.2(c)(5); see *Medicare Claims Processing Manual*, Chapter 3 § 40.3>

1. Non-covered Inpatient Stay

- a. If the inpatient stay is not covered by Part A (e.g., exhaustion of benefits, lack of medical necessity) an inpatient Part B claim is submitted on a type of bill 012X and the outpatient services prior to the inpatient order are not combined to the inpatient claim but rather are billed to Part B as outpatient services on a type of bill 013X. <*Medicare Claims Processing Manual*, Chapter 4 § 10.12>

## B. Overview

Factors to consider when determining the applicability of the preadmission payment window:

- The relationship between the inpatient and outpatient provider
- Services excluded from the rule
- The date the service was furnished

## C. The Relationship Between the Inpatient and Outpatient Provider

1. An outpatient service is potentially subject to the preadmission payment window if:
  - a. The service was furnished by the same hospital where the patient was admitted, including at a provider-based department; or
  - b. The service was furnished by an entity that is “wholly owned or operated” by the hospital where the patient was admitted, including freestanding clinics. <See 42 C.F.R. 412.2(c)(5)(i); see 63 Fed. Reg. 6866; 76 Fed. Reg. 73281>
    - i. An entity is considered to be “wholly operated” by a hospital if the hospital has “exclusive responsibility for conducting and overseeing the entity’s routine operations.” <See 42 C.F.R. 412.2(c)(5)(i)>
    - ii. An entity that is “wholly sponsored” by a non-profit or not-for-profit admitting hospitals is treated the same as a wholly owned entity for purposes of the payment window. <See Medicare Claims Processing Manual, Chapter 3 § 40.3 B>
  - c. Although not stated in the regulations, according to the Medicare Claims Processing Manual, preadmission services furnished “by another entity under arrangements with the hospital” are also subject to packaging. <See Medicare Claims Processing Manual, Chapter 3 § 40.3(B)>

## D. Outpatient Services Excluded from Application of the Rule

1. Ambulance services <See 42 C.F.R. 412.2(c)(5)(iii)> ;
2. Maintenance renal dialysis services <See 42 C.F.R. 412.2(c)(5)(iii)> ;
3. Physician professional services <See 63 Fed. Reg. 6866>;
4. Part A services furnished by skilled nursing facilities, home health agencies and hospices<See Medicare Claims Processing Manual, Chapter 3 § 40.3 B and C>; and

5. Visit services provided at a Rural Health Clinic (RHC) paid under their all-inclusive rate (AIR) or a Federally Qualified Health Center (FQHC) paid under the FQHC PPS rate that replaced the former AIR for FQHCs. <76 Fed. Reg. 73281; Medicare Benefit Policy Manual, Chapter 13 § 10.2>
  - a. Services provided at an RHC or FQHC paid under Part B rather than the AIR or FQHC PPS rate are subject to the payment window. <76 Fed. Reg. 73281-2>
6. Outpatient Services Not Covered or Payable under Part B
  - a. Services not covered or payable under Part B should not be bundled into a subsequent inpatient admission. <See Medicare Claims Processing Manual, Chapter 3 §40.3 C>

CMS provides the example of non-covered self-administered drugs provided before an inpatient admission (i.e., before the inpatient order) as an example of a non-covered item that should not be billed on the inpatient claim under the preadmission payment window rule.

#### E. The Date the Outpatient Services were Furnished

1. The day of admission:
  - a. An outpatient service provided by the hospital (or a wholly owned entity) on the same date as the patient's admission to the hospital is bundled into the inpatient admission, regardless of whether it is clinically related to the admission. <See 42 C.F.R. 412.2(c)(5)(ii) and (iv); 42 C.F.R. 412.405 (a)(2) and (3)>
2. Prior to admission:
  - a. Inpatient Prospective Payment System (IPPS) hospitals
    - i. An outpatient *diagnostic* service provided by the hospital (or a wholly owned entity) in the *three calendar days* prior to the patient's admission to the hospital is bundled into the inpatient admission, regardless of whether it is clinically related to the admission. <See 42 C.F.R. 412.2(c)(5)(ii)>
      - a) Definition of Diagnostic Services

- 1) CMS provides a list of revenue codes and HCPCS codes considered diagnostic for purposes of the rule in *Medicare Claims Processing Manual*, Chapter 3 § 40.3 B, included in the materials behind the outline.

**Caution:** The list of diagnostic revenue codes and HCPCS codes provided in the Medicare Claims Processing Manual may not be exhaustive.

- 2) A service is considered diagnostic if it is an examination or procedure to which the patient is subjected or which is performed on material derived from the patient to obtain information to aid in the assessment of a medical condition or the identification of a disease and includes tests given to determine the nature and severity of an ailment or injury. <"Frequently Asked Questions CR7502 (Bundling of Payment for Services Provided to Outpatients Who Later are Admitted as Inpatients:3-Day Payment Window and the Impacts on Wholly Owned or Wholly Operated Physician Offices)", Q3, published 6/14/2012 on CMS.gov, "Three Day Payment Window" website>
  - ii. An outpatient *non-diagnostic* service provided by the hospital (or a wholly owned entity) in the *three calendar days* prior to the patient's admission to the hospital is bundled into the inpatient admission if it is related to the patient's admission. <See 42 C.F.R. 412.2(c)(5)(iv)>
    - a) Related is defined as being clinically associated with the reason for the patient's inpatient admission. <75 Fed. Reg. 50347>
- b. Non-IPPS hospitals, except Critical Access Hospitals
  - i. An outpatient *diagnostic* service is bundled into a subsequent inpatient admission if it is provided on the calendar day prior to the patient's admission to the hospital (and is furnished by the hospital or a wholly owned or operated entity and is not excluded from the rule as discussed above). <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3; *MLN Matters SE20024*>
  - ii. An outpatient *non-diagnostic* service is bundled into a subsequent inpatient admission if it is provided on the calendar day prior to the patient's admission to the hospital and it is *related* to the patient's admission (and is furnished by the hospital or a wholly owned or operated entity and is not excluded from the rule as discussed above). <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3>

### Case Study 3

**Facts:** A patient comes to the emergency department of an IPPS hospital with syncope at 7pm on October 1. Diagnostic tests are performed on October 1 and the patient is placed in observation at 8pm. At 6am on October 2 additional diagnostic tests are performed and the patient is discharged home at 7 am. The patient is later admitted as an inpatient at the same hospital on October 5 for altered mental status and syncopal episodes. Are these services subject to the pre-admission payment window?

## F. Billing Issues

### 1. Edits applied by Line-Item Date of Service (LIDOS)

- a. The payment window applies to outpatient services within three calendar days (or one calendar day for non-IPPS hospitals) prior to the patient's inpatient admission, even if the services are part of a continuous outpatient encounter that began prior to the payment window. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 B and C>
  - i. CMS pre-admission packaging edits are applied by line-item dates of service (LIDOS) for each service and not the "from" and "through" date of a claim. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 B and D>
  - ii. Application to Observation Services
    - a) Observation services are billed with the LIDOS that they began, rather than the date they are rendered. <*Medicare Claims Processing Manual*, Chapter 4 § 290.2.2>
    - b) Observation services with a LIDOS prior to the payment window will not trigger pre-admission packaging edits, even though some of the services may occur within the payment window and are presumably subject to packaging if they are related to the inpatient admission. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 B and C>

### 2. Combining Outpatient Services on the Inpatient Claim

- a. The diagnosis codes, procedures, and charges for outpatient services subject to the payment window should be combined on to the inpatient claim. <See 63 *Fed. Reg.* 6866; see *Medicare Claims Processing Manual*, Chapter 3 § 40.3 C>

- i. The HCPCS codes for outpatient procedures should be converted to ICD-10-PCS procedure codes for reporting on the inpatient claim. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 C>
  - ii. The ICD-10-PCS procedure codes for outpatient services occurring in the payment window should be reported with the date they were provided, even though this date precedes the inpatient admission date. <See CMS email notice to the HOSPITALS-ACUTE-L@LIST.NIH.GOV list on September 9, 2010>
3. Billing Clinically Distinct Services Separately
  - a. Outpatient non-diagnostic services that are clinically distinct or independent from the reason for inpatient admission are considered unrelated and are separately billable. <See 42 C.F.R. 412.2(c)(5)(iv); 75 Fed. Reg. 50348>
    - i. The provider must report condition code 51 when separately billing unrelated outpatient non-diagnostic services provided in the payment window prior to an inpatient admission. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3 C; *One Time Notification Transmittal 796*>
4. Billing by Freestanding (i.e., non-Provider Based) Wholly Owned or Operated Physician Practices and Entities
  - a. Technical services subject to the payment window are billed on the inpatient claim. <See *Medicare Claims Processing Manual*, Chapter 3 § 40.3; *MLN Matters SE20024*>
    - i. Although CMS has instructed providers to include charges for services subject to the payment window occurring in wholly owned or operated entities on the inpatient claim, it is unclear how to determine the amount of charge to be combined to the inpatient claim. <76 Fed. Reg. 73283>
  - b. Professional services associated with technical services subject to the payment window are billed separately on a supplier/1500 claim with modifier -PD. <*Medicare Claims Processing Manual*, Chapter 12 §§ 90.7 and 90.7.1; *MLN Matters SE20024*>
    - i. Services billed with modifier -PD that have a professional/technical component split (e.g., certain diagnostic services) will be paid at the professional component rate. <76 Fed. Reg. 73286; *Medicare Claims Processing Manual*, Chapter 12 § 90.7.1>

- ii. Services billed with modifier -PD that do not have a professional/technical component split (e.g., E/M services) will be paid at the applicable facility rate. <76 Fed. Reg. 73286; Medicare Claims Processing Manual, Chapter 12 § 90.7.1>
- c. Services provided in the payment window but not subject to bundling (i.e., unrelated non-diagnostic services) are billed as usual, with no special modifiers or other indicators. <Medicare Claims Processing Manual, Chapter 12 § 90.7>

#### **Case Study 4**

**Facts:** On September 13, a Medicare patient was seen in General Memorial Hospital's provider-based outpatient clinic for longstanding renal complications of their diabetes. The physician ordered laboratory tests and scheduled a follow-up visit for 2 days later. Later that same day, the patient presented to GMH's laboratory to have the tests ordered by the physician.

On September 15, the patient presented to GMH's provider-based outpatient clinic to review the laboratory tests with the physician. Later that day, the patient fell down the stairs in their home and was admitted to GMH for open reduction of multiple fractures. General Memorial Hospital is an IPPS hospital. Is the hospital entitled to separate payment for the clinic visit on September 13<sup>th</sup>? The laboratory test on September 13? The clinic visit on September 15?

#### IV. Billing Outpatient Non-Covered Items or Services

- A. Handout 8 is an overview of billing for outpatient non-covered services, as discussed in this section.
- B. An Effective ABN was Issued
  - 1. Bill to the MAC with Occurrence Code 32
    - a. When an ABN is provided, the claim for the items or services for which the ABN was given must be filed with an occurrence code 32. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
    - b. The occurrence date should be the date that the ABN was given to the beneficiary. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>
  - 2. Bill as Covered Charges
    - a. Items or services for which an ABN was given should be billed as "covered charges." <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>

3. Other Covered or Non-covered Services Billed on the Same Claim

- a. If other covered or non-covered items or services are billed on the same claim, modifier –GA should be used to identify those items or services for which an ABN was given. <Medicare Claims Processing Manual, Chapter 1 § 60.4.1>

4. Collecting Payment from the Beneficiary Upon Denial by the Intermediary

- a. Where the MAC/FI denies payment for services, for which an effective ABN was provided, payment for the services may be collected from the Medicare beneficiary. <Medicare Claims Processing Manual, Chapter 30 § 50.12>
- b. Medicare charge limits do not apply to services for which an effective ABN was given. <Medicare Claims Processing Manual, Chapter 30 § 50.12>

C. An ABN was Required but Not Issued

1. “Fully Non-Covered Claim”

- a. A “fully non-covered claim” is billed without indicators of liability or only provider liability indicators and is used to bill entirely non-covered services for which the hospital is liable. “Fully non-covered claims” are allowed but not required for hospital liable services. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>
- b. Indicators of Liability on “Fully Non-covered Claims”
  - i. No indicators of liability at the claim or line level (i.e., no condition code 21, a claim level indicator of beneficiary liability), or
  - ii. All indicators of liability at the claim or line level must indicate that the hospital, and not the beneficiary, is liable (i.e., no modifier -GY, a line level indicator of beneficiary liability). <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>

2. Bill as Non-Covered Charges

- a. Charges should be billed as non-covered. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3.1>

3. Other Covered or Non-covered Services Billed on the Same Claim

- a. Modifier -GZ indicates a line item expected to be denied as not reasonable and necessary, but for which no ABN was given. The -GZ triggers automatic denial and hospital liability. <Medicare Claims Processing Manual, Chapter 1 §§ 60.1.3.1 and 60.4.2, Table 8; Medicare Program Integrity Manual, Chapter 3 § 3.3.1.1 (G)>

D. At Request of the Beneficiary (Demand Bill), a Voluntary ABN May Have Been Issued

1. Bill to the Intermediary with Condition Code 20

- a. Where the hospital expects a service to be non-covered due to a categorical or technical denial, but the beneficiary requests that the claim be submitted to Medicare for a determination anyway, the claim should be submitted with condition code 20. This has traditionally been referred to as a “demand bill.” <Medicare Claims Processing Manual, Chapter 1 § 60.3.1>
  - i. The beneficiary has the right to have any service provided to them billed to Medicare for an official payment decision that they may appeal if they choose. <Medicare Claims Processing Manual, Chapter 1 § 60.3.1>

2. Bill as Non-Covered Charges

- a. The charges for which coverage is “in dispute” must be submitted as non-covered charges. <Medicare Claims Processing Manual, Chapter 1 § 60.3.1>

3. Other Covered Services Billed on Same Claim

- a. Covered services may, but are not required, to appear on the same claim as non-covered services billed with condition code 20. <Medicare Claims Processing Manual, Chapter 1 § 60.3.2>

4. Other Non-covered Services Billed on a Separate Claim

- a. Other non-covered services (i.e., billed with occurrence code 32 or condition code 21) must be submitted on a separate claim from demand bill services. Claims with condition code 20 are exempt from same day billing rules. <Medicare Claims Processing Manual, Chapter 1 § 60.3.2>

5. Voluntary ABN Issued (Limitation on Liability does not apply)
  - a. Modifier –GX may be used to identify items subject to categorical or technical denial for which an ABN was given anyway (i.e., voluntary ABN). <Medicare Claims Processing Manual Transmittal 1921 B>
  - i. Modifier –GX may be reported with other liability modifiers, including modifier –GY. <Medicare Claims Processing Manual Transmittal 1921>

#### E. Billing for Denial Notices for Secondary Payors

1. Bill to the Intermediary with Condition Code 21
  - a. Where services are clearly non-covered (i.e., categorical or technical denials) but a claim is being submitted to Medicare for purposes of obtaining a denial notice that can be forwarded to secondary payers, the claim should be submitted with condition code 21. These types of claims are sometimes referred to as “no-pay bills.” <Medicare Claims Processing Manual, Chapter 1 § 60.1.3>
2. Bill as Non-Covered Charges
  - a. All charges on no-pay bills must be submitted as non-covered charges. <Medicare Claims Processing Manual, Chapter 1 § 60.1.3>
3. Other Covered and Non-covered ABN Services Billed on Same Claim
  - a. Non-covered services being billed for a denial must be submitted with modifier -GY, rather than condition code 21, when they appear on the same claim as covered and other non-covered services. <Medicare Claims Processing Manual, Chapter 1 § 60.1.2 (B)>
  - i. Modifier -GY indicates a line item that is statutorily excluded or does not meet the definition of any Medicare benefit (i.e., categorical and technical denial). Modifier -GY triggers beneficiary liability. <Medicare Claims Processing Manual, Chapter 1 § 60.4.2, Table 8>
4. Voluntary ABN Issued (Limitation on Liability does not apply)
  - a. Modifier –GX may be used to identify items subject to categorical or technical denial for which an ABN was given anyway (i.e., voluntary ABN). <Medicare Claims Processing Manual, Transmittal 1921 B>
  - i. Modifier –GX may be reported with other liability modifiers, including modifier –GY. <Medicare Claims Processing Manual, Transmittal 1921>

## CASE STUDIES WITH ANALYSIS

### Case Study 1

**Facts:** A patient received cardiac rehab services on March 1, 5, 7 and 9. The patient was then admitted as an inpatient to the hospital on March 11-15 for pancreatitis unrelated to their cardiac condition. The patient returned to cardiac rehab on March 19 and received cardiac rehab services on March 19, 21, 23, 26, 28 and 30. How should the cardiac rehab services be billed?

**Analysis:** Cardiac rehabilitation is categorized as a repetitive service and must be billed on a separate monthly claim. When an inpatient stay occurs during the same month as a repetitive service, occurrence span code 74 and the dates of the inpatient stay must be reported to prevent a duplicate claim edit. <Medicare Claims Processing Manual, Chapter 1 § 50.2.2>

## Case Study 2

**Facts:** A Medicare patient receiving chemotherapy treatments is registered as a “series” patient at the hospitals’ Cancer Center. The patient received chemotherapy treatments on November 1, 6, 11 and 18. On November 6, the patient is registered as an outpatient at the provider-based clinic where they see their family practitioner related to the flu. The visit was coded with E/M code G0463. Would it be permissible to bill the clinic visit separately from the chemotherapy treatments?

**Analysis:** The clinic visit must be billed on the same claim as the chemotherapy treatment on November 6. The provider may either include the clinic visit on the series account for the chemotherapy treatments or separate the chemotherapy treatments onto separate claims in order to bill the chemotherapy and clinic visit on November 6 on the same claim and the chemotherapy on November 1 and the chemotherapy on November 11 and 18 separately. <Medicare Claims Processing Manual, Chapter § 50.2.2>

### Case Study 3

**Facts:** A patient comes to the emergency department of an IPPS hospital with syncope at 7pm on October 1. Diagnostic tests are performed on October 1 and the patient is placed in observation at 8pm. At 6am on October 2 additional diagnostic tests are performed and the patient is discharged home at 7 am. The patient is later admitted as an inpatient at the same hospital on October 5 for altered mental status and syncopal episodes. Are these services subject to the pre-admission payment window?

**Analysis:** The emergency department visit, the 4 hours of observation and diagnostic tests performed on October 1 are not subject to the payment window and should be billed separately. The diagnostic tests and 7 hours of observation on October 2 are subject to the payment window and should be billed on the inpatient claim. <Medicare Claims Processing Manual, Chapter 3 § 40.3 B and C>

#### Case Study 4

**Facts:** On September 13, a Medicare patient was seen in General Memorial Hospital's provider-based outpatient clinic for longstanding renal complications of their diabetes. The physician ordered laboratory tests and scheduled a follow-up visit for 2 days later. Later that same day, the patient presented to GMH's laboratory to have the tests ordered by the physician.

On September 15, the patient presented to GMH's provider-based outpatient clinic to review the laboratory tests with the physician. Later that day, the patient fell down the stairs in their home and was admitted to GMH for open reduction of multiple fractures. General Memorial Hospital is an IPPS hospital. Is the hospital entitled to separate payment for the clinic visit on September 13<sup>th</sup>? The laboratory test on September 13? The clinic visit on September 15?

**Analysis:** The hospital is entitled to separate payment for the clinic visit on September 13 because it is a non-diagnostic service and is not clinically related to the admission on September 15. The hospital must report condition code 51 on the outpatient claim for the clinic visit. The laboratory test on September 13 is bundled to the inpatient admission under the three-day payment window because all diagnostic services in the three days before an inpatient admission must be included on the inpatient claim, whether they are related or not. The hospital is also not entitled to separate payment for the clinic visit on September 15 because all services on the day of an inpatient admission must be included on the inpatient claim. <Medicare Claims Processing Manual, Chapter 3 § 40.3 B and C>



## Excerpt from Medicare Claims Processing Manual, Chapter 1

code 30 in 60 day increments until discharge. They no longer have to continually adjust bills until physical discharge or death. The last bill shall contain a discharge patient status code.

These instructions for hospitals and SNFs apply to all providers, including those receiving Periodic Interim Payments (PIP). Providers should continue to submit no-pay bills until discharge.

**NOTE:** For stays that necessitate the reporting of more than ten OSCs (i.e., more OSCs than the claim formats allow), Long Term Care Hospitals, Inpatient Psychiatric Facilities, and Inpatient Rehabilitation Facilities shall refer to instructions provided in Chapter 32, section 74.3 of this manual.

### **50.2.2 - Frequency of Billing for Providers Submitting Institutional Claims with Outpatient Services**

**(Rev. 2092, Issued: 11-12-10, Effective: 04-01-11, Implementation: 04-04-11)**

Repetitive Part B services furnished to a single individual by providers that bill institutional claims shall be billed monthly (or at the conclusion of treatment). The instructions in this subsection also apply to hospice services billed under Part A, though they do not apply to home health services. Consolidating repetitive services into a single monthly claim reduces CMS processing costs for relatively small claims and in instances where bills are held for monthly review. Services repeated over a span of time and billed with the following revenue codes are defined as repetitive services:

<b>Type of Service</b>	<b>Revenue Code(s)</b>
DME Rental	0290 – 0299
Respiratory Therapy	0410, 0412, 0419
Physical Therapy	0420 – 0429
Occupational Therapy	0430 – 0439
Speech-Language Pathology	0440 – 0449
Skilled Nursing	0550 – 0559
Kidney Dialysis Treatments	0820 – 0859
Cardiac Rehabilitation Services	0482, 0943
Pulmonary Rehabilitation Services	0948

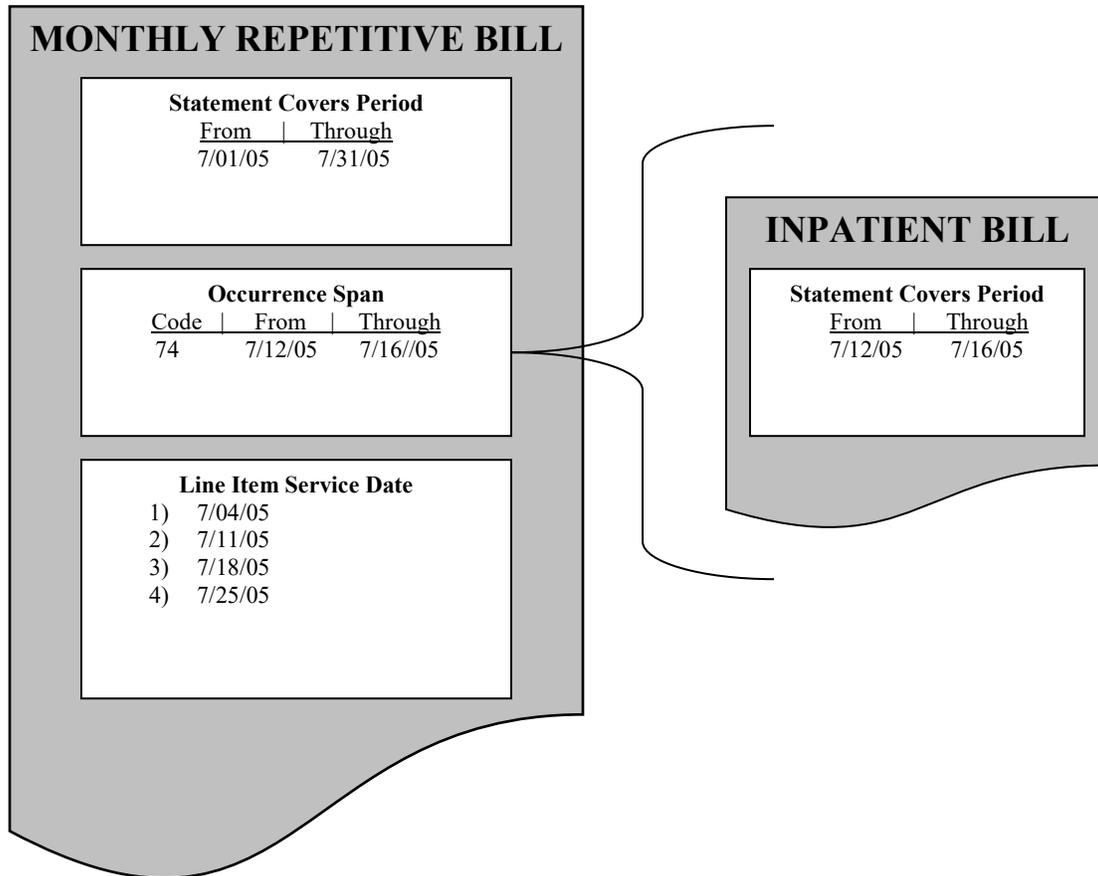
Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to monthly billing cycles.



Where there is an inpatient stay, or outpatient surgery, or outpatient hospital services subject to OPPS, during a period of repetitive outpatient services, one bill for repetitive services shall nonetheless be submitted for the entire month as long as the provider uses an occurrence span code 74 on the monthly repetitive bill to encompass the inpatient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. CWF and shared systems must read occurrence span 74 and recognize the beneficiary cannot receive non-repetitive services while receiving repetitive services, and consequently, is

on leave of absence from the repetitive services. This permits submitting a single, monthly bill for repetitive services and simplifies Contractor review of these bills. The following is an illustration explaining this scenario:

### Leave of Absence “Carve-Out” Example

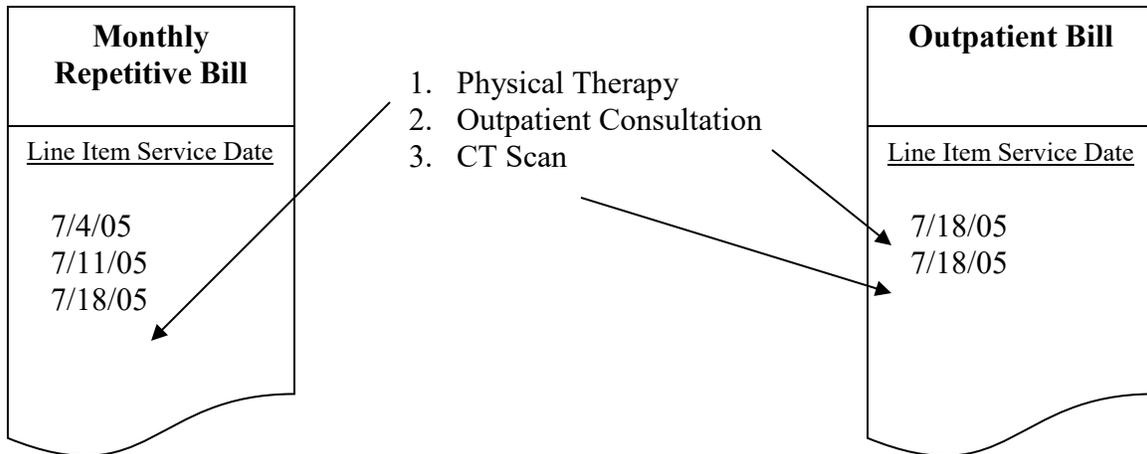


-  Any items and/or services in support of the repetitive service shall be reported on the same claim even if the revenue code(s) reported with those supported services are not on the repetitive revenue code list (**NOTE:** Supporting items and/or services are those in which are needed specifically in the performance of the repetitive service. Examples may include disposable supplies, drugs or equipment used to furnish the repetitive service).
-  However, to facilitate APC recalibration, do not report unrelated one-time, non-repetitive services that have the same date of service as a repetitive service (even if both the non-repetitive service and the repetitive service are paid under OPSS). If a non-repetitive OPSS service is provided on the same date as a repetitive service, report the non-repetitive OPSS services, along with any packaged and/or services related to the non-repetitive OPSS service, on a separate OPSS claim. For example, if a chemotherapy drug is administered on a day a repetitive service is also rendered, report the chemotherapy drug, its administration, its related supplies, etcetera, on a separate claim from the

monthly repetitive services claim. Similarly, as shown below in the illustration, “Example: Monthly Repetitive Billing Procedure,” a physical therapy treatment (which is a repetitive service because it is reported under a revenue code on the repetitive service list) is administered on the same day an outpatient consultation and a CT scan are furnished, report the physical therapy service on the claim with the other physical therapy services provided during the applicable month. Report the visit for the consultation and the CT scan on a separate claim.



### Example: Monthly Repetitive Billing Procedure



Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service. However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill. The services may all be reported on the same claim or billed separately by date of service as illustrated below:

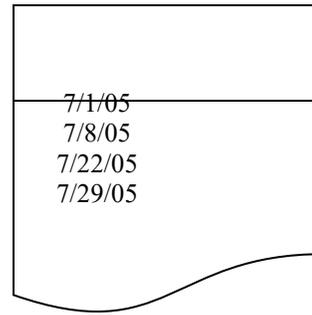
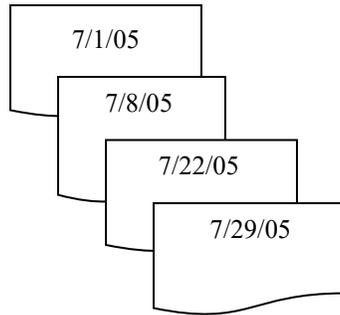


## Billing Procedures for Recurring Services Not Defined as Repetitive

1) Submit multiple bills for each date of service (include only the recurring service and its related services):

**OR**

2) Submit a monthly bill for all line item dates of service (for the entire month's recurring services with all services related to the recurring services):



Indian Health Service Hospitals, Maryland hospitals, as well as hospitals located in Saipan, Guam, American Samoa, and the Virgin Islands are not subject to OPPS. In addition, hospitals that furnish only inpatient Part B services are also exempt from OPPS. Bills for ambulatory surgery in these hospitals shall contain on a single bill all services provided on the same day as the surgery except kidney dialysis services, which are billed on a 72X bill type. Non-ASC services furnished on a day other than the day of surgery shall not be included on the outpatient surgical bill.

See Chapter 16 for clinical diagnostic lab services paid under the fee schedule when included with outpatient bills for other services.

Contractors periodically review bills from providers known to be furnishing repetitive services to determine if they are billing more frequently than proper. Techniques that may be used are:

- Sample review of bills to determine if most are for a monthly period (by using from and thru dates or number of services). This may be done manually or electronically. Contractors may rely on informal communications from their medical review staff, and

Contractors should educate providers that bill improperly. Contractors shall:

- Return bills with an explanation and request proper billing to providers that continue to bill improperly.
- Not return bills where the treatment plan is completed indicating discontinued services because the beneficiary dies or moves.

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- o All outpatient hospital Part B bills (bill types 12X, 13X with condition code 41, 13X without condition code 41 or 14X) with the exception of bills from hospitals in Maryland, Indian health service, CAHs, and hospitals located in Saipan, American Samoa, and Guam;
- o CMHC bills (bill type 76X);
- o CORF and HHA bills containing certain HCPCS codes as described in "New HCPCS Coding Requirements for CORFs and HHAs" above (bill types 75X or 34X); and
- o Any bill containing a condition code 07 with certain HCPCS codes as described in "New HCPCS Coding Requirements for CORFs and HHAs" above.

**NOTE:** For bill type 34X only vaccines and their administration, splints, casts, and antigens will be paid under OPSS. For bill type 75X only vaccines and their administration will be paid under OPSS. For bills containing condition code 07 only splints, casts, and antigens will be paid under OPSS.

### **Discontinuation of Bill Type 83X for Hospitals Subject to OPSS**

Since bill type 83X "Ambulatory Surgical Center Services to Hospital Outpatients" will not be utilized under OPSS, hospitals are required, beginning with claims with dates of service on or after August 1, 2000, to report in Form Locator 6 "Statement Covers Period From Date" the earliest date services were rendered. As a result, pre-operative laboratory services will always have a line item date of service within the from and through dates on the claim. The instructions in §3626.4 of the MIM only apply to claims with dates of service prior to August 1, 2000.

Indian health service hospitals continue to bill for surgeries utilizing bill type 83X.

### **Discontinuation of Value Code 05 Reporting**

With line item date of service reporting, there will be no way to correctly allocate professional component charges reported in value code 05 to specific line items on the claim. As a result, advise your hospitals that currently report professional component charges in value code 05 on outpatient claims to no longer include the professional component amount in their charges and to discontinue reporting the professional component in value code 05.

### **Provider Reporting Requirements**

Advise your providers paid under OPSS not to include July 2000 and August 2000 dates of service on the same claim. Standard systems must edit to assure that a hospital or CMHC claim does not contain dates of service that span July 2000 and August 2000. In addition, advise your hospitals and CMHCs that every effort should be made to report all services performed on the same day on the same claim to assure proper payment under OPSS. Return claims submitted for the same date of service to the provider (except duplicates or those containing condition codes 20, 21 or G0) with a notification that an adjustment bill should be submitted. Claims with condition code G0 should not be automatically rejected as a duplicate claim.

### **Procedures for Submitting Late Charges**

Hospitals and CMHCs may not submit a late charge bill (Step 5 in the third position of the bill type) for bill types 12X, 13X, 14X, and 76X effective for claims with dates of service on or after August 1, 2000. They must submit an adjustment bill for any services required to be billed with HCPCS codes, units and line item dates of service by reporting a 7 in the third position of the bill type. Separate bills containing only late charges will not be permitted.

The submission of an adjustment bill, instead of a late charge bill, will ensure proper duplicate detection, bundling, correct application of coverage policies and proper editing by OCE and payment under OPSS.

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This content is from the eCFR and is authoritative but unofficial.

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## Title 42 - Public Health

### Chapter IV - Centers for Medicare & Medicaid Services, Department of Health and Human Services

#### Subchapter B - Medicare Program

#### Part 412 - Prospective Payment Systems for Inpatient Hospital Services

##### Subpart A - General Provisions

**Authority:** 42 U.S.C. 1302 and 1395hh.

**Source:** 50 FR 12741, Mar. 29, 1985, unless otherwise noted.

### § 412.2 Basis of payment.

- (a) **Payment on a per discharge basis.** Under both the inpatient operating and inpatient capital-related prospective payment systems, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment rate for each discharge (as defined in § 412.4) is determined according to the methodology described in subpart D, E, or G of this part, as appropriate, for operating costs, and according to the methodology described in subpart M of this part for capital-related costs. An additional payment is made for both inpatient operating and inpatient capital-related costs, in accordance with subpart F of this part, for cases that are extraordinarily costly to treat.
- (b) **Payment in full.**
- (1) The prospective payment amount paid for inpatient hospital services is the total Medicare payment for the inpatient operating costs (as described in paragraph (c) of this section) and the inpatient capital-related costs (as described in paragraph (d) of this section) incurred in furnishing services covered by the Medicare program.
  - (2) The full prospective payment amount, as determined under subpart D, E, or G and under subpart M of this part, is made for each stay during which there is at least one Medicare payable day of care. Payable days of care, for purposes of this paragraph include the following:
    - (i) Limitation of liability days payable under the payment procedures for custodial care and services that are not reasonable and necessary as specified in § 411.400 of this chapter.
    - (ii) Guarantee of payment days, as authorized under § 409.68 of this chapter, for inpatient hospital services furnished to an individual whom the hospital has reason to believe is entitled to Medicare benefits at the time of admission.
  - (3) If a patient is admitted to an acute care hospital and then the acute care hospital meets the criteria at § 412.23(e) to be paid as a LTCH, during the course of the patient's hospitalization, Medicare considers all the days of the patient stay in the facility (days prior to and after the designation of LTCH status) to be a single episode of LTCH care. Medicare will not make payment under subpart H for any part of the hospitalization. Payment for the entire patient stay (days prior to and after the designation of LTCH status) will be made in accordance with the requirements specified in § 412.521. The requirements of this paragraph (b)(3) apply only to a patient stay in which a patient is in an acute care hospital and that hospital is designated as a LTCH on or after October 1, 2004.

- (c) **Inpatient operating costs.** The prospective payment system provides a payment amount for inpatient operating costs, including -
- (1) Operating costs for routine services (as described in § 413.53(b) of this chapter), such as the costs of room, board, and routine nursing services;
  - (2) Operating costs for ancillary services, such as radiology and laboratory services furnished to hospital inpatients;
  - (3) Special care unit operating costs (intensive care type unit services, as described in § 413.53(b) of this chapter);
  - (4) Malpractice insurance costs related to services furnished to inpatients; and
  -  (5) Preadmission services otherwise payable under Medicare Part B furnished to a beneficiary on the date of the beneficiary's admission to the hospital and during the 3 calendar days immediately preceding the date of the beneficiary's admission to the hospital that meet the condition specified in paragraph (c)(5)(i) of this section and at least one of the conditions specified in paragraphs (c)(5)(ii) through (c)(5)(iv).
    - (i) The services are furnished by the hospital or by an entity wholly owned or operated by the hospital. An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. An entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity.
    - (ii) For services furnished after January 1, 1991, the services are diagnostic (including clinical diagnostic laboratory tests).
    - (iii) For services furnished on or after October 1, 1991, through June 24, 2010, the services are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient and are not the following:
      - (A) Ambulance services.
      - (B) Maintenance renal dialysis.
    - (iv) Nondiagnostic services furnished on or after June 25, 2010, other than ambulance services and maintenance renal dialysis services, that are furnished on the date of the beneficiary's inpatient admission or on the first, second, or third calendar day immediately preceding the date of the beneficiary's inpatient admission and the hospital does not attest that such services are unrelated to the beneficiary's inpatient admission.
- (d) **Inpatient capital-related costs.** For cost reporting periods beginning on or after October 1, 1991, the capital prospective payment system provides a payment amount for inpatient hospital capital-related costs as described in part 413, subpart G of this chapter.
- (e) **Excluded costs.** The following inpatient hospital costs are excluded from the prospective payment amounts and are paid for on a reasonable cost basis:
- (1) Capital-related costs for cost reporting periods beginning before October 1, 1991, and an allowance for return on equity, as described in §§ 413.130 and 413.157, respectively, of this chapter.
  - (2) Direct medical education costs for approved nursing and allied health education programs as described in § 413.85 of this chapter.

- (3) Costs for direct medical and surgical services of physicians in teaching hospitals exercising the election in § 405.521 of this chapter.
- (4) The acquisition costs of hearts, kidneys, livers, lungs, pancreas, and intestines (or multivisceral organs) incurred by approved transplant programs.
- (5) The costs of qualified nonphysician anesthetists' services, as described in § 412.113(c).
- (6) For cost reporting periods beginning on or after October 1, 2020, the costs of allogeneic hematopoietic stem cell acquisition, as described in § 412.113(e), for the purpose of an allogeneic hematopoietic stem cell transplant.
- (f) **Additional payments to hospitals.** In addition to payments based on the prospective payment system rates for inpatient operating and inpatient capital-related costs, hospitals receive payments for the following:
  - (1) Outlier cases, as described in subpart F of this part.
  - (2) The indirect costs of graduate medical education, as specified in subparts F and G of this part and in § 412.105 for inpatient operating costs and in § 412.322 for inpatient capital-related costs.
  - (3) Costs excluded from the prospective payment rates under paragraph (e) of this section, as provided in § 412.115.
  - (4) Bad debts of Medicare beneficiaries, as provided in § 412.115(a).
  - (5) ESRD beneficiary discharges if such discharges are ten percent or more of the hospital's total Medicare discharges, as provided in § 412.104.
  - (6) Serving a disproportionate share of low-income patients, as provided in § 412.106 for inpatient operating costs and § 412.320 for inpatient capital-related costs.
  - (7) The direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§ 413.75-413.83 of this chapter.
  - (8) For discharges on or after June 19, 1990, and before October 1, 1994, and for discharges on or after October 1, 1997, a payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia. For discharges occurring on or after October 1, 2005, the additional payment is made based on the average sales price methodology specified in subpart K, part 414 of this subchapter and the furnishing fee specified in § 410.63 of this subchapter.
  - (9) Special additional payment for certain new technology as specified in §§ 412.87 and 412.88 of subpart F.
  - (10) A payment adjustment for the additional resource costs of domestic National Institute for Occupational Safety and Health approved surgical N95 respirators as specified in § 412.113.
- (g) **Payment adjustment for certain replaced devices.** CMS makes a payment adjustment for certain replaced devices, as provided under § 412.89.

[50 FR 12741, Mar. 29, 1985]

**Editorial Note:** For FEDERAL REGISTER citations affecting § 412.2, see the List of CFR Sections Affected, which appears in the Finding Aids section of the printed volume and at [www.govinfo.gov](http://www.govinfo.gov).

## Excerpt from Medicare Claims Processing Manual, Chapter 3

- Has been admitted to another institution at any time during the leave of absence, submit an adjusted bill.

The hospital shows the day the patient left the hospital as the date of discharge. (A beneficiary cannot be an inpatient of two institutions at the same time.)

**NOTE:** Home health or outpatient services provided during a leave of absence do not affect the leave and no discharge bill is required unless the above events occur.

### 40.3 - Outpatient Services Treated as Inpatient Services

(Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD-10, Implementation: ICD-10: Upon Implementation of ICD-10, ASC X12: September, 23 2014)

#### A. - Outpatient Services Followed by Admission Before Midnight of the Following Day (Effective For Services Furnished Before October 1, 1991)

When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and A/B MACs (A) apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and included in the Part A payment. See Chapter 1 for A/B MAC (A) requirements for detecting duplicate claims in such cases.

#### B. - Preadmission Diagnostic Services (Effective for Services Furnished On or After January 1, 1991)

- 🔑 Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

This provision does not apply to ambulance services and maintenance renal dialysis services (see the Medicare Benefit Policy Manual, Chapters 10 and 11, respectively). Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (IPPS) as well as those hospitals and units excluded from IPPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission. The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children's hospitals; and cancer hospitals.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore outpatient diagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, outpatient diagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

 The technical portion of any outpatient diagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient diagnostic services included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient diagnostic 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 diagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

 An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For purposes of the 3-day (or 1-day) payment window policy, a "sponsorship" is treated the same as an "ownership", and a "non-profit" or "not-for-profit" entity is treated the

same as a “for-profit” entity. Thus, outpatient diagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary’s inpatient admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary’s inpatient stay at the not-for-profit hospital.

 For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or CPT codes:

<b>Code</b>	<b>Description</b>
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

Code	Description
074X	EEG
0918-	Testing- Behavioral Health
092X	Other diagnostic services

The CWF rejects services furnished January 1, 1991, or later when outpatient bills for diagnostic services with through dates or last date of service (occurrence span code 72) fall on the day of admission or any of the 3 days immediately prior to admission to an IPPS or IPPS-excluded hospital. This reject applies to the bill in process, regardless of whether the outpatient or inpatient bill is processed first. Hospitals must analyze the two bills and report appropriate corrections. For services on or after October 31, 1994, for hospitals and units excluded from IPPS, CWF will reject outpatient diagnostic bills that occur on the day of or one day before admission. For IPPS hospitals, CWF will continue to reject outpatient diagnostic bills for services that occur on the day of or any of the 3 days prior to admission. Effective for dates of service on or after July 1, 2008, CWF will reject diagnostic services when the line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital or on the day of admission or one day prior to admission for hospitals excluded from IPPS.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

**C. - Other Preadmission Services** (Effective for Services Furnished On or After October 1, 1991 and Before June 25, 2010)

Nondiagnostic outpatient services that are related to a beneficiary's hospital admission and that are provided by the admitting hospital, or by an entity that is wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the 3 days immediately preceding and including the date of the beneficiary's admission are deemed to be inpatient services and are included in the inpatient payment. Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the principal diagnosis code assigned for both the preadmission services and the inpatient stay. Thus, whenever Part A covers an admission, the hospital may bill nondiagnostic preadmission services to Part B as outpatient services **only** if they are **not** related to the admission. The A/B MAC (A) shall assume, in the absence of evidence to the contrary, that such bills are not admission related and, therefore, are not deemed to be inpatient (Part A) 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 to Part B. This provision applies only when the beneficiary has Part A coverage. This provision does not apply to ambulance services and maintenance renal dialysis. Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to IPPS as well as those hospitals and units excluded from IPPS (see section B above).

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission.

Hospitals must not include on a claim for an inpatient admission any outpatient nondiagnostic services that are not payable under Part B. For example, oral medications that are considered self-administered drugs under Part B are not payable under the outpatient prospective payment system (OPPS) and must not be bundled on an inpatient claim for purposes of the 3-day (or 1-day) payment window policy.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a critical access hospital (CAH). Therefore, outpatient nondiagnostic services rendered to a beneficiary by a CAH, or by an entity that is wholly owned or operated by a CAH, during the payment window, must not be bundled on the claim for the beneficiary's inpatient admission at the CAH. However, admission-related outpatient nondiagnostic services rendered to a beneficiary at a CAH that is wholly owned or operated by a non-CAH hospital, during the payment window, are subject to the 3-day (or 1-day) payment window policy.

The technical portion of any admission-related outpatient nondiagnostic service rendered to a beneficiary at a hospital-owned or hospital-operated physician clinic or practice during the payment window is subject to the 3-day (or 1-day) payment window policy (see MCPM, chapter 12, sections 90.7 and 90.7.1).

The 3-day (or 1-day) payment window policy does not apply to outpatient nondiagnostic services that are included in the rural health clinic (RHC) or Federally qualified health center (FQHC) all-inclusive rate (see MCPM, chapter 19, section 20.1).

Outpatient nondiagnostic 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 nondiagnostic services that were furnished prior to the span of the payment window may be separately billed to Part B.

An entity is considered to be "wholly owned or operated" by the hospital if the hospital is the **sole** owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting

or overseeing the facility's routine operations), regardless of whether it also has the authority to make the policies.

For purposes of the 3-day (or 1-day) payment window policy, a “sponsorship” is treated the same as an “ownership”, and a “non-profit” or “not-for-profit” entity is treated the same as a “for-profit” entity. Thus, admission-related outpatient nondiagnostic services provided by the admitting not-for-profit hospital, or by an entity that is wholly sponsored or operated by the admitting not-for-profit hospital, to a beneficiary during the 3 days (or 1 day) immediately preceding and including the date of the beneficiary’s inpatient admission are deemed to be inpatient services and must be bundled on the claim for the beneficiary’s inpatient stay at the not-for-profit hospital.

Hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission are subject to the 3-day payment window.

Effective for dates of service on or after July 1, 2008 and before June 25, 2010, CWF will reject claims for nondiagnostic services when the following is met:

- 1) There is an exact match (for all digits) between the principal diagnosis code assigned for both the preadmission services and the inpatient stay, and
- 2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPSS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPSS).

**D. - Other Preadmission Services** (Effective for Services Furnished On or After June 25, 2010)

Beginning on or after June 25, 2010, the definition of “other services related to the admission” (i.e., admission-related outpatient “nondiagnostic” services) is revised for purposes of the 3-day (or 1-day) payment window policy. Except for the following changes, the other requirements in section 40.3.C continue to be applicable.

-  For outpatient nondiagnostic 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 IPSS (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) by adding a condition code 51 (definition “51 - Attestation of Unrelated Outpatient Non-diagnostic Services”) to the

separately billed outpatient non-diagnostic services claim. Beginning on or after April 1, 2011, providers may submit outpatient claims with condition code 51 for outpatient claims that have a date of service on or after June 25, 2010.

 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 above requirements. 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. In combining on the inpatient bill the diagnoses, procedures, and charges for the outpatient services, a hospital must convert CPT codes to ICD procedure codes and must only include outpatient diagnostic and admission-related nondiagnostic services that span the period of the payment window.

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. Hospitals must 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.

Effective for dates of service on or after June 25, 2010, CWF will reject outpatient claims for nondiagnostic services when the following occurs:

- 1) Condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services") is not included on the outpatient claim, and
- 2) The line item date of service (LIDOS) falls on the day of admission or any of the 3 days immediately prior to an admission to an IPPS hospital (or on the day of admission or one day prior to admission for hospitals excluded from IPPS).

### **40.3.1 - Billing Procedures to Avoid Duplicate Payments (Rev. 1, 10-01-03)**

#### **HO-400H**

The hospital must install adequate billing procedures to avoid submission of duplicate claims. This includes duplicate claims for the same service and outpatient bills for nonphysician services considered included in the DRG for a related inpatient admission in the facility or in another hospital.

Where the hospital bills separately for nonphysician services provided to a patient either on the day before admission to a PPS hospital or during a patient's inpatient stay, the claim will be rejected by the A/B MAC (A) as a duplicate and the hospital may be subject to sanction penalties per §1128A of the Act.

**Kimberly Hoy**

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**From:** Medicare Acute Care provider information [HOSPITALS-ACUTE-L@LIST.NIH.GOV] on behalf of CMS CMSProviderResource [CMSProviderResource@CMS.HHS.GOV]  
**Sent:** Thursday, September 09, 2010 3:50 PM  
**To:** HOSPITALS-ACUTE-L@LIST.NIH.GOV  
**Subject:** Medicare's 3-Day/1-Day Payment Window Policy: Outpatient Services Treated as Inpatient  
Medicare's 3-Day/1-Day Payment Window Policy: Outpatient Services Treated as Inpatient

During the Hospital Open Door Forum call on August 26<sup>th</sup>, 2010, hospitals expressed concerns regarding billing for procedures performed in the outpatient setting that must be bundled on the inpatient hospital bill in order to comply with the 3-day (or 1-day) payment window policy. CMS recently issued a memorandum to providers regarding a statutory change in the policy pertaining to admission-related outpatient non-diagnostic services (<http://www.cms.gov/AcuteInpatientPPS/Downloads/JSMTDL-10382%20ATTACHMENT.pdf>). Some hospitals were concerned that the Medicare claims processing systems may have edits that do not allow hospitals to bill the ICD-9-CM procedure code dates correctly for outpatient non-diagnostic services provided during the 3 calendar days (or 1 calendar day) immediately preceding the admission date on the inpatient claim.

CMS has verified that the Medicare claims processing system **does** allow the ICD-9-CM procedure code dates for non-diagnostic services provided up to 3 calendar days prior to the admission date on the inpatient claim. Therefore, hospitals are able to bill correctly for admission-related outpatient non-diagnostic services (that is, bundle the services on the inpatient hospital claim) without modifying dates on the inpatient claim. The CMS foresees no system issues that prevent hospitals from billing appropriately according to the 3-day (or 1-day) payment window policy. If providers encounter systems difficulties, they should contact their local contractor, CMS Regional Office, or CMS Central Office, accordingly.

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other services provided under Part A, that is, services furnished by skilled nursing facilities and hospices. We have revised the regulations at §§ 412.2(c)(5) and 413.40(c)(2) to reflect this policy. We note that diagnostic services provided by these facilities that would be payable under Part B are subject to the window.

*Comment:* Three commenters requested that maintenance renal dialysis not be subject to the payment window. These commenters noted that patients must have dialysis on an ongoing basis. Because most patients receive dialysis three times a week, for any hospitalization, the patient will have at least one dialysis treatment falling in the payment window period. Regardless of the reason for the hospitalization, the patient would have received the dialysis treatment.

One of the commenters expressed the opinion that inclusion of dialysis services in the payment window provision would increase administrative costs for hospital-owned dialysis units because, prior to billing, they would have to research the diagnosis involved in every hospitalization and decide whether or not it is "related to dialysis." The commenter stated that, in such cases, dialysis units might seek payment or credit from the hospital rather than from Medicare, and that this would disrupt billing patterns and subject hospital-owned units to still greater fiscal constraints in the form of further administrative costs. Another commenter believes that excluding all outpatient chronic maintenance dialysis treatments would be easy to implement and administer. A simple directive could be issued to all Medicare contractors with instructions that dialysis services are not subject to the payment window provision.

*Response:* We agree with the commenters that outpatient chronic renal dialysis services are distinct from the type of hospital services that Congress designed the payment window provision to address. Maintenance dialysis must be provided to patients on a scheduled basis as long as they suffer from end-stage renal disease. Thus, it is not an inpatient service that hospitals have attempted to move outside the inpatient stay and corresponding hospital prospective payment. Therefore, in this rule, we are revising §§ 412.2(c) and 413.40(c) to exclude maintenance renal dialysis services from the preadmission services that are subject to the payment window.

*Comment:* Only one commenter responded to our request for comment on different approaches to defining "services related to the inpatient

admission." The commenter suggested that one possible approach would be to define certain preadmission services that are never considered to be related to the admission. The commenter provided the following list of preadmission services (in addition to maintenance renal dialysis) that should always be considered not related to the subsequent admission:

- Outpatient chemotherapy.
- Blood transfusions for chronic conditions (e.g., hemophilia and renal failure).
- Physical therapy, occupational therapy, speech therapy, other types of rehabilitative therapy, and respiratory therapy for chronic or long-term care conditions.
- Radiation therapy.

In addition, the commenter believed that any diagnostic tests associated with these services should also be excluded from the window.

*Response:* We agree with the commenter that certain services should not be subject to the provisions of the payment window. As noted above, we have determined that Part A services (such as home health, hospice, and skilled nursing facility services), ambulance services, and chronic maintenance renal dialysis should be excluded from the payment window.

With regard to the additional services requested by the commenter to be added to that list, we are not persuaded that these services should be excluded from the payment window. Outpatient chemotherapy and radiation therapy are time-limited treatments for specific medical conditions. This is also true of the rehabilitation services listed by the commenter. We do not believe that these services fall into the same category as maintenance dialysis. We are also not convinced that blood transfusions for chronic conditions should be excluded. These transfusions are often related to a change in condition or an injury; unlike dialysis, they are not generally provided to patients on a weekly schedule.

Therefore, we are not adding any of these services to our list of exclusions. We note that we have defined services as being related to the admission only when there is an exact match between the ICD-9-CM diagnosis code assigned for both the preadmission services and the inpatient stay. Concerning the request to exclude diagnostic services associated with excluded services, we believe that the statute requires that all diagnostic services be included in the payment window.

*Comment:* One commenter stated that the hospital industry is making new arrangements for the provision of health care. Many hospitals are establishing

facilities licensed as free-standing clinics, owned and operated under a corporate umbrella, with a hospital responsible for conducting or overseeing the clinic's routine operations. The commenter requested that we address the difficulty of converting outpatient charges for preadmission testing from the HCFA-1500 to the UB-92 inpatient hospital billing form.

*Response:* We believe that the current procedures for billing Medicare for preadmission services, as set forth in section 415.6 of the Medicare Hospital Manual (HCFA-Pub. 10), are clear. When services are furnished within the 3-day payment window, they are included on the Part A bill, the HCFA-1450 (also known as the UB-92), for the inpatient stay. They are not separately billed under Part B. The charges, revenue codes, and ICD-9-CM diagnosis and procedure codes are all included on the HCFA-1450.

In the context of this comment concerning hospital arrangements, we would like to address the numerous telephone and written inquiries we have received concerning the definition of an entity "wholly owned or operated" by the hospital. The inquiries we have received include descriptions of various ownership/operation arrangements and requests to verify whether or not the 3-day payment window applies to each case. In general, if a hospital has direct ownership or control over another entity's operations, then services provided by that other entity are subject to the 3-day window. However, if a third organization owns or operates both the hospital and the entity, then the window provision does not apply. The following are examples of how this general policy is applied.

*Arrangement:* A hospital owns a physician clinic or a physician practice that performs preadmission testing for the hospital.

*Policy:* A hospital-owned or hospital-operated physician clinic or practice is subject to the payment window provision. The technical portion of preadmission diagnostic services performed by the physician clinic or practice must be included in the inpatient bill and may not be billed separately. A physician's professional service is not subject to the window.

*Arrangement:* Hospital A owns Hospital B, which in turn owns Hospital C. Does the payment window apply if preadmission services are performed at Hospital C and the patient is admitted to Hospital A?

*Policy:* Yes. We would consider that Hospital A owns both Hospital B and Hospital C, and the payment window would apply in this situation.