Medicare Learning Network
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CMS
Information for Medicare Fee-for-Service Health Care Professionals

News Flash – On Friday, December 3, the Office of National Coordinator for Health Information Technology (ONC) will host a free day-long public roundtable on "Personal Health Records — Understanding the Evolving Landscape." The roundtable is designed to inform ONC's Congressionally mandated report on privacy and security requirements for non-Covered Entities (non-CEs), with a focus on personal health records (PHRs) and related service providers (Section 13424 of the HITECH Act). Mark your calendars now—registration and additional conference information will be available in October at *http://healthit.hhs.gov/PHRroundtable* on the Internet.

MLN Matters® Number: MM7142
Related Change Request (CR) #: 7142
Related CR Release Date: October 29, 2010
Effective Date: June 25, 2010
Related CR Transmittal #: R796OTN
Implementation Date: April 4, 2011

Clarification of Payment Window for Outpatient Services Treated as Inpatient Services

Provider Types Affected

This article is for Inpatient Acute Care hospitals that bill Medicare fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Make sure your billing staff is aware of the following changes to the Medicare policy for payment of outpatient services on either the date of an inpatient admission or during the three calendar days immedicatley preceding an inpatient date of admission. These changes impact dates of service on or after June 25, 2010.

Background

Section 102 of the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010" pertains to Medicare's policy for payment of outpatient services provided on either the date of a beneficiary's inpatient 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 (or during the one calendar day preceding the date of a beneficiary's inpatient admission to a non-subsection (d) hospital).

Under the 3-day payment window, 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 provided during the payment window. The new law makes the policy pertaining to admission-related outpatient nondiagnostic services more consistent with common hospital billing practices.

All services other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital), provided on the same date of the inpatient admission are deemed related to the admission and are not separately billable.

Additionally, outpatient nondiagnostic services, other than ambulance services (as denoted by revenue code 054X on the claim line) and maintenance renal dialysis services (Type of Bill 072X or Type of Bill 13X with HCPCS code G0257 along with other dialysis service lines identified by revenue codes 0270, 0304, 0634, 0635 and/or 0636 on the same date as G0257), provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's 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 inpatient 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 to the separately billed outpatient non-diagnostic services claim.

Providers may submit outpatient claims with condition code 51 starting April 1, 2011. Outpatient claims processed prior to April 4, 2011, but with dates of service on or after June 25, 2010 may need to be adjusted by the provider if they were rejected by Medicare. Such adjustments should be made after April 4, 2010.

The statute makes no changes to the existing policy regarding billing of diagnostic services. All diagnostic services provided to a Medicare beneficiary by a subsection (d) hospital subject to the inpatient prosepctive payment system (IPPS), or an entity wholly owned or operated by the hospital, on the date of the beneficiary's inpatient admission and during the 3 calendar days (1 calendar day for a non-subsection (d) hospital) immediately preceding the date of admission would continue to be required to be included on the bill for the inpatient stay.

Additional Information

The official instruction, CR 7142, issued to your FI or MAC regarding this change may be viewed at *http://www.cms.gov/Transmittals/downloads/R796OTN.pdf* on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your FI or MAC at their toll-free number, which may be found at *http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.

News Flash - Each Office Visit is an Opportunity. Medicare patients give many reasons for not getting their annual flu vaccination, but the fact is that there are 36,000 flu-related deaths in the United States each year, on average. More than 90% of these deaths occur in people 65 years of age and older. Please talk with your Medicare patients about the importance of getting their annual flu vaccination. This Medicare-covered preventive service will protect them for the entire flu season. And remember, vaccination is important for health care workers too, who may spread the flu to high risk patients. Don't forget to immunize yourself and your staff. Protect your patients. Protect your family. Protect yourself. Get Your Flu Vaccine - Not the Flu. Remember – Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza vaccine and its administration, as well as related educational resources for health care professionals and their staff, please visit *http://www.cms.gov/MLNProducts/Downloads/Flu_Products.pdf* and *http://www.cms.gov/AdultImmunizations* on the CMS website.