Client Advisory

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Health Care

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Changes to the Medicare Three-Day Payment Window

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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) (the Act), § 102 of which changes the definition of admission-related non-diagnostic services furnished on the date of admission or during the three calendar days prior to the date of admission (the "3-day payment window")[1], effective for services furnished on or after June 25, 2010.

Section 102(a) of the Act makes no change concerning diagnostic services, but defines "other services related to the admission" as all non-diagnostic services (other than ambulance and maintenance renal dialysis services) furnished:

(1) on the date of the inpatient admission; or

(2) "during the 3 days . . . immediately preceding the date of such 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."

Services furnished on or after June 25, 2010, that meet this definition must be bundled with the inpatient claim, and may not be billed separately to Medicare Part B.

In an August 9, 2010, memorandum to Medicare providers, CMS stated that "[t]he new law makes the policy pertaining to admission-related outpatient non-diagnostic services more consistent with common hospital billing practices." The new law, however, provides little guidance to providers in determining which services are now "related" to the admission.

On August 16, 2010, the Federal Register published CMS' final rulemaking for the FY 2011 hospital inpatient prospective payment system (IPPS), which included an interim final rule with comment period regarding the new 3-day payment window rule. In the preamble to the interim final rule, CMS stated that an outpatient service is "related" to an admission if it is "clinically associated with the reason for a patient's inpatient admission." According to the preamble, CMS is taking a broad view of what it means to be "clinically related" to an inpatient admission. CMS stated that, other than ambulance and maintenance renal dialysis services, ALL non-diagnostic services furnished by a hospital (or an entity wholly

[1] The 3-day payment window rule applies to hospitals that are subject to the inpatient prospective payment system (IPPS); a 1-day payment window rule applies to hospitals not subject to IPPS.

owned or wholly operated by the hospital) on the date of admission or during the 3-day payment window are deemed to be related to the admission and, therefore, must be bundled with the inpatient stay. The only exception is if, when submitting a claim for an outpatient service furnished during the 3-day payment window, the hospital attests that the non-diagnostic service is "clinically distinct or independent from the reason for the beneficiary's admission." Hospitals would also be required to maintain documentation to support their assertion that a service is unrelated. CMS stated that it intends to establish a process whereby hospitals can attest that a service is unrelated to the admission. CMS also intends to develop a condition code or modifier, similar to that used when a beneficiary has an inpatient admission on the same date as a discharge from an unrelated admission, which will identify outpatient services furnished during the 3-day payment window that are not clinically associated with the inpatient admission.

In addition, § 102(c)(1) of the Act prohibits the Secretary from reopening a claim, adjusting a claim or making a payment pursuant to any request for payment under Medicare for services described in § 102(c)(2) for purposes of treating services furnished during the 3-day payment window as unrelated to a patient's inpatient admission. Services described in § 102(c)(2) "are other services related to the admission . . . which were previously included on a claim or request for payment submitted under part A of [Medicare] for which a reopening, adjustment, or request for payment under part B of [Medicare], was not submitted prior to [June 25, 2010]."

Accordingly, for services furnished prior to June 25, 2010, the following billing scenarios reflect a reasonable application of § 102(c) of the Act:

1) **Services for Which the Hospital Has Already Submitted Claims:** Claims for these services may not be adjusted to unbundle unrelated non-diagnostic services.

2) **Services for Which Claims Have Not Been Submitted:** Claims for these non-diagnostic services furnished during the three days prior to the date of admission may be billed separately if the services do not meet the pre-Act definition of related (i.e., principal diagnosis code match between the outpatient service and the inpatient admission).

The CMS August 9, 2010, memo is available at:
http://www.cms.gov/AcuteInpatientPPS/Downloads/JSMTDL-10382%20ATTACHMENT.pdf

The August 16, 2010, Federal Register is available at:
http://edocket.access.gpo.gov/2010/pdf/2010-19092.pdf