Client Advisory

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Health Care

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Update to the Medicare Three-Day Payment Window Rule

On October 29, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a Transmittal entitled "Clarification of Payment Window for Outpatient Services Treated as Inpatient Services" (Transmittal 796), which provides instruction on how to submit claims for outpatient services furnished within three days of an inpatient admission that are unrelated to the admission. This long-awaited instruction flows from § 102 of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Pub. L. 111-192) (the Act), which changed 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 of the Act also requires that all admission-related non-diagnostic services be bundled with the claim for the related inpatient stay. The Act left unclear, however, what constitutes services "related" to an admission.

CMS's final rulemaking for the FY 2011 hospital inpatient prospective payment system (IPPS), published in the August 16, 2010, Federal Register, 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, other than ambulance and maintenance renal dialysis services, ALL non-diagnostic services furnished by a hospital (or an entity wholly 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."

Transmittal 796 provides a means for hospitals to make such an attestation. It states that, beginning April 1, 2011, hospitals may submit claims for non-diagnostic services furnished on or after June 25, 2010, that the hospital attests "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." The definition of condition code 51 is "Attestation of Unrelated Outpatient Non-diagnostic Services." Claims for unrelated non-diagnostic services furnished during the 3-day payment window with dates of services on or after June 25, 2010 that were submitted without condition code 51 will need to be adjusted by the provider if they were rejected by Medicare's Fiscal Intermediary Standard System or Common Working File.

CMS Transmittal 796 is available at:
http://www.cms.gov/transmittals/downloads/R796OTN.pdf

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

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[1] The 3-day payment window rule applies to hospitals that are subject to the IPPS; a one-day payment window rule applies to hospitals not subject to IPPS.