CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 796	**Date: October 29, 2010**
	Change Request 7142

SUBJECT: Clarification of Payment Window for Outpatient Services Treated as Inpatient Services

I. SUMMARY OF CHANGES: This Change Request shows how to implement the Preservation of Access to Care Act (PACA) Section 102. The new law makes the policy pertaining to admission-related outpatient non-diagnostic services more consistent with common hospital billing practices.

EFFECTIVE DATE: June 25, 2010
IMPLEMENTATION DATE: April 4, 2011

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	n/a

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One Time Notification

Pub. 100-20	Transmittal: 796	Date: October 29, 2010	Change Request: 7142

SUBJECT: Clarification of Payment Window for Outpatient Services Treated as Inpatient Services

Effective Date: June 25, 2010

Implementation Date: April 4, 2011

I. GENERAL INFORMATION

A. Background: On June 25, 2010, President Obama signed into law the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010," Pub. L. 111-192. Section 102 of the law pertains to Medicare's policy for payment of outpatient services provided on either the date of a beneficiary's 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).

B. Policy: 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 non-diagnostic 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) 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 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 (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 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.

Providers may submit outpatient claims with condition code 51 starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010. Outpatient claims with a date of service on or after June 25, 2010, that did not contain condition code 51 received prior to April, 1, 2011, will need to be adjusted by the provider if they were rejected by FISS or CWF.

The statute makes no changes to the existing policy regarding billing of *diagnostic services* (see section 40.3(B) of Pub100-4, Chapter 3). All diagnostic services provided to a Medicare beneficiary by a subsection (d) hospital subject to the 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 shall still be included on the bill for

the inpatient stay.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7142.1	FISS shall allow the new condition code 51 to be accepted on outpatient claims.						X				
7142.2	CWF shall modify current edits to no longer set based on match of Principle ICD-9-CM Diagnosis code but to reject claims with a Line item Date of Service (LIDOS) on or after June 25, 2010, for outpatient non-diagnostic services other than ambulance and maintenance renal dialysis services on the same date of service as an inpatient admission.									X	
7142.3	CWF shall modify current edits to no longer set based on match of Principle ICD-9-CM Diagnosis code but to reject claims with a LIDOS on or after June 25, 2010, for outpatient non-diagnostic services (other than ambulance and maintenance renal dialysis services) provided within 3 calendar days prior to an inpatient admission at a subsection (d) hospital.									X	
7142.3.1	CWF shall bypass the edits modified in 7142.3 to allow only non-diagnostic outpatient charges on or after June 25, 2010, within the 3 calendar day payment window for subsection (d) providers if the provider has added Condition Code 51 to the claim. Diagnostic services shall still be rejected.									X	
7142.4	CWF shall modify current edits to no longer set based on match of Principle ICD-9-CM Diagnosis code but to reject claims with a LIDOS on or after June 25, 2010, for outpatient non-diagnostic services (other than ambulance and maintenance renal dialysis services) provided within 1 calendar day prior to an inpatient admission at a non-subsection (d) hospital.									X	
7142.4.1	CWF shall bypass the edits modified in 7142.4 to allow only non-diagnostic outpatient charges on or after June 25, 2010, within the 1 calendar day payment window for non-subsection (d) providers if the provider has added Condition Code 51 to the claim. Diagnostic services shall still be rejected.									X	
7142.5	CWF shall not bypass the edits modified in 7142.3.1 and 7142.4.1 if the provider has added Condition Code 51 and the LIDOS of the charge on or after June 25, 2010, that is on the outpatient claim is the same as the									X	

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
	admission date on the Inpatient claim.										
7142.6	CWF shall bypass payment window edits for ambulance and maintenance renal dialysis services. In other words, lines for services on or after June 25, 2010, that meet the following conditions: • Lines for ambulance services, which are identified with revenue code 054X • Lines for maintenance renal dialysis services, which are identified by the following: o TOB 013X that contains a line item with HCPCS G0257 along with other dialysis service lines identified by revenue codes 0270, 0304, 0634, 0635 and/or 0636 billed on the same date as the dialysis service G0257. **Note:** all services and supplies that are part of the maintenance dialysis are excluded from the payment window bundling rules									X	
7142.7	FISS shall disable any edits constructed by FISS pertaining to Payment Window for Outpatient Services Treated as Inpatient Services (although not a complete listing, here are some examples: 38041-38045, 38048, 38049, 38067-38069, 38108, and 38109)						X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7142.8	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s):
Policy: Valerie Miller on (410) 786-4535 or Amy Gruber on (410) 786-1542
Claims Processing: Fred Rooke at fred.rooke@cms.hhs.gov or 410-786-6987
Joe Bryson at joseph.bryson@cms.hhs.gov or 410-786-2986
Cami DiGiacamo at cami.digiacomo@cms.hhs.gov or (410) 786-5888
Sarah Shirey-Losso at sarah.shirey-losso@cms.hhs.gov or 410-786-0187

Post-Implementation Contact(s): Appropriate Project Officer or Contractor Manager

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.