CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 156 **Date: APRIL 30, 2004**

CHANGE REQUEST 3200

I. SUMMARY OF CHANGES: Clarification of the proper payment procedure for hospitals in Maryland that are under the jurisdiction of the Health Services Cost Review Commission. In addition, clarifies frequency of billing and 3-day payment window for these hospitals.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2004
***IMPLEMENTATION DATE: October 4, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/50/50.2.1/Inpatient Billing from Hospitals and SNFs
R	1/50/50.2.2/Frequency of Billing for Outpatient and Services to FIs
R	3/20/ Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)
R	3/40/40.3/Outpatient Services Treated as Inpatient Services
R	4/Table of Contents
N	4/141/ Maryland Waiver Hospitals

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Business Requirements

Pub. 100-04	Transmittal: 156	Date: APRIL 30, 2004	Change Request 3200

SUBJECT: **Clarification of payments and billing procedures for hospitals subject to the Maryland waiver.**

I. GENERAL INFORMATION

A. Background: Hospital rate regulation in Maryland was created by an act of the 1971 Maryland legislature. The law created the Health Services Cost Review Commission (HSCRC), giving broad responsibilities regarding the public disclosure of hospital financial data and trustee relationship and was given the authority, beginning July 1, 1974, to set hospital rates which would apply to all Maryland residents.

The Maryland law gave the HSCRC authority to set hospital rates for all payers. However, federal law, which takes precedence, governed the methods by which Medicare and Medicaid paid hospitals. After negotiation with Medicare, HSCRC obtained, effective July 1, 1977, a waiver of federal law that required Medicare and Medicaid to begin paying hospitals on the basis of HSCRC-approved rates. It has come to our attention that services furnished at hospitals in Maryland subject to the HSCRC are not being paid according to the terms of the agreement.

This instruction is being issue to clarify the following for hospitals subject to the MD waiver:

- Proper payment procedures for outpatient services,
- Frequency of billing, and
- 3-day payment window.

B. Policy: In accordance with Section 1814 (b) (3) of the Act, services provided by hospitals in Maryland subject to the HSCRC are paid according to the terms of the waiver, that is 94% of submitted charges subject to any existing deductible, coinsurance, and non-covered charges policies.

In addition, hospitals in Maryland under the jurisdiction of the HSCRC are subject to the 3-day payment window and 30-day billing cycles. Common Working File (CWF) will remove the current bypass for Maryland providers from all 3-day window edits.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their website 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 must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3200.1	Intermediaries that process outpatients claims from hospitals in Maryland that are under the jurisdiction of the HSCRC shall process them in accordance with the terms of the waiver, that is 94% of submitted charges subject to any unmet existing deductible, coinsurance, and non-covered charges policies. Payment should not be made under a fee schedule or other payment method for items and services provided with the following exceptions: • Reference laboratory services which are paid under the clinical diagnostic laboratory fee schedule (bill type 14X); • Ambulance services which are subject to the ambulance fee schedule.	**FIs, SSM**
3200.2	Intermediaries that process outpatients claims from hospitals in Maryland that are under the jurisdiction of the HSCRC shall inform them that they are exempt from all alternate payment methods, except as noted in 3200.1.	**FIs**
3200.3	Intermediaries that process inpatient claims from hospitals in Maryland that are under the jurisdiction of the HSCRC shall process them in accordance with the terms of the waiver, that is 94% of submitted charges subject to any unmet existing deductible, coinsurance, and non-covered policies.	**FIs, SSM**
3200.4	Intermediaries shall allow hospitals in Maryland that are under the jurisdiction of the HSCRC to submit outpatient bills in accordance with frequency billing standards and inpatient bills in accordance with monthly billing cycles.	**FIs**
3200.5	Intermediaries shall subject hospitals in Maryland that are under the jurisdiction of the HSCRC, that provide inpatient services, to the 3-day payment window.	**FIs**

3200.6	Common Working File shall remove the current bypass for Maryland providers from all 3-day window edits.	**CWF**

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date:** October 4, 2004 **Pre-Implementation Contact(s):** William Ruiz and Faith Ashby (outpatient) or Sarah Shirey (inpatient) **Post-Implementation Contact(s):** Contact the appropriate Regional Office.	**These instructions should be implemented within your current operating budget.**

50.2.1 - Inpatient Billing From Hospitals and SNFs

(Rev. 156, 04-30-04)

A3-3603, R1882A3, R1892A3

Inpatient services in TEFRA hospitals (i.e., psychiatric hospitals or units, cancer and children's hospitals) and SNFs are billed:

- Upon discharge of the beneficiary;
- When the beneficiary' benefits are exhausted;
- When the beneficiary's need for care changes; or
- On a monthly basis.

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

Providers will submit a bill to the FI when a beneficiary in a SNF ceases to need active care (occurrence code 22), or a beneficiary in one of these hospitals ceases to need hospital level care (occurrence code 22). FIs shall not separate the occurrence code 31 and occurrence span code 76 on two different bills.

Each bill must include all applicable diagnoses and procedures. However, interim bills are not to include charges billed on an earlier claim since the "From" date on the bill must be the day after the "Thru" date on the earlier bill. No-payment bills should be submitted until the beneficiary is discharged.

Inpatient acute-care PPS hospitals, inpatient rehabilitation facilities (IRFs), and long term care hospitals (LTCHs) may interim bill in at least 60-day intervals. Subsequent bills must be in the adjustment bill format. Each bill must include all applicable diagnoses and procedures.

The LTCHs will also submit a bill when the beneficiary's benefits exhaust. This permits them to bill a secondary insurer when Medicare ceases to make payment.

Initial inpatient acute care PPS hospital, inpatient rehabilitation facility, and a long-term care hospital interim claims must have a patient status code of 30 (still patient). When processing interim PPS hospital bills, providers use the bill designation of 112 (interim bill - first claim). Upon receipt of a subsequent bill, the FI must cancel the prior bill and replace it with one of the following bill designations:

- For subsequent interim bills, bill type 117 with a patient status of 30 (still patient); or

- For subsequent discharge bills, bill type 117 with a patient status of one of the following:

o 01 - Discharged to home or self care;

o 02 - Discharged/transferred to another short-term general hospital;

o 03 - Discharged/transferred to SNF;

o 04 - Discharged/transferred to an ICF;

o 05 - Discharged/transferred to another type of institution (including distinct part), or referred for outpatient services to another institution;

o 06 - Discharged/transferred to home under care of an organized home health service organization;

o 07 – Left against medical advice;

o 08 - Discharged/transferred to home under care of a home IV drug therapy provider;

o 20 - Expired (or did not recover - Religious Non-Medical Healthcare Institution patient);

o 43 - Discharged/transferred to a Federal hospital (effective for discharges on and after October 1, 2003);

o 50 - Hospice - home

o 51 - Hospice - medical facility

o 61 - Discharged/transferred within this institution to a hospital-based Medicare approved swing bed.

o 62 - Discharged/transferred to an inpatient rehabilitation facility including distinct part units of a hospital

o 63 - Discharged/transferred to long term care hospitals

o 64 - Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare

o 65 - Discharged/transferred to a psychiatric hospital or psychiatric part unit of a hospital (effective April 1, 2004)

o 71 - Discharged/transferred/referred to another institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

o 72 - Discharged/transferred/referred to this institution for outpatient services as specified by the discharge plan of care (deleted October 1, 2003)

All inpatient providers must submit bills when any of the following occur, regardless of the date of the prior bill (if any):

- Benefits are exhausted;
- The beneficiary ceases to need a hospital level of care (all hospitals);
- The beneficiary falls below a skilled level of care (SNFs and hospital swing beds; or
- The beneficiary is discharged.

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.

50.2.2 - Frequency of Billing for Outpatient and Services to FIs

(Rev. 156, 04-30-04)

Repetitive Part B services to a single individual from providers that bill FIs may be billed monthly (or at the conclusion of treatment). These instructions also apply to hospice services billed under Part A. This reduces CMS processing costs for relatively small claims and in instances where bills are held for monthly review. Examples of repetitive Part B services with applicable revenue codes include:

Type of Service	**Revenue Code(s)**
DME Rental	0290 - 0299
Therapeutic Radiology	0330 - 0339
Therapeutic Nuclear Medicine	0342
Respiratory Therapy	0410 - 0419
Physical Therapy	0420 - 0429
Occupational Therapy	0430 - 0439
Speech Pathology	0440 - 0449
Home Health Visits	0550 - 0559
Kidney Dialysis Treatments	0820 - 0859
Cardiac Rehabilitation Services	0482, 0943
Psychological Services	0910 - 0919 (in a psychiatric facility)

This does not apply to Home Health Services. See Chapter 10 for requirements for HHAs.

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

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 may be submitted for the entire month if the provider uses an occurrence span code 74 to encompass the in-patient stay, day of outpatient surgery, or outpatient hospital services subject to OPPS. CWF and shared systems must read occurrence span 74 and recognize that the beneficiary cannot receive outpatient services while an inpatient, and consequently is on leave of absence from repetitive services. This permits submitting a single bill for the month and simplifies FI review of these bills. This is in addition to the bill for the inpatient stay or outpatient surgery.
Other one-time Part B services may be billed upon completion of the service.
Bills for outpatient hospital services subject to OPPS must contain on a single bill all services provided on same day except claims containing condition codes 20, 21, or G0 (zero) or kidney dialysis services, which are billed on a 72X bill type. If an individual OPPS service is provided on the same day as an OPPS repetitive service, the individual OPPS service must be billed on the OPPS monthly repetitive claim. 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 must 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-OPPS services furnished on a day other than the day of surgery must 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.
FIs 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. FIs may rely on informal communications from their medical review staff, and
- Modification of duplicate screens to detect bills that meet duplicate criteria except for billing period, but which fall in the same 30 day period.

FIs should educate providers that bill improperly. They must:

- 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.

20 - Payment Under Prospective Payment System (PPS) Diagnosis Related Groups (DRGs)

(Rev. 156, 04-30-04)

A3-3610, HO-415

A - General

The Social Security Amendments of 1983 (P.L. 98-21) provided for establishment of a prospective payment system (PPS) for Medicare payment of inpatient hospital services. (See §20.4 for corresponding information for PPS capital payments and computation of capital and operating outliers for FY 1992.) Under PPS, hospitals are paid a predetermined rate per discharge for inpatient hospital services furnished to Medicare beneficiaries. Each type of Medicare discharge is classified according to a list of DRGs. These amounts are, with certain exceptions, payment in full to the hospital for inpatient operating costs. Beneficiary cost-sharing is limited to statutory deductibles, coinsurance, and payment for noncovered items and services. Section 4003 of OBRA of 1990 (P.L. 101-508) expands the definition of inpatient operating costs to include certain preadmission services. (See §40.3.)

The statute excludes children's hospitals and cancer hospitals, hospitals located outside the 50 States~~, the District of Columbia, and Puerto Rico are also excluded.~~ In addition to these categorical exclusions, the statute provides other special exclusions, such as hospitals that are covered under State reimbursement control systems. These excluded hospitals and units are paid on the basis of reasonable costs subject to the target rate of increase limits.

In accordance with Section 1814 (b) (3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission (provider numbers 21000-21099) are paid according to the terms of the waiver, that is 94% of submitted charges subject to any unmet Part B deductible and coinsurance.

For discharges occurring on or after April 1, 1988, separate standardized payment amounts are established for large urban areas and rural areas. Large urban areas are urban areas with populations of more than 1,000,000 as determined by the Secretary of HHS on the basis of the most recent census population data. In addition, any New England County Metropolitan Area (NECMA) with a population of more than 970,000 is a large urban area.

OBRA 1987 required payment of capital costs under PPS effective with cost reporting periods that began October 1, 1991, or later. A 10-year transition period was provided to protect hospitals that had incurred capital obligations in excess of the standardized national rate from major disruption. High capital cost hospitals are known as "hold harmless" hospitals. The transition period also provides for phase-in of the national Federal capital payment rate for hospitals with capital obligations that are less than the national rate. New hospitals that open during the transition period are exempt from capital PPS payment for their first two years of operation. Hospitals and hospital distinct part units that are excluded from PPS for operating costs are also excluded from PPS for capital costs.

Capital payments are based on the same DRG designations and weights, outlier guidelines, geographic classifications, wage indexes, and disproportionate share percentages that apply to operating payments under PPS. The indirect teaching adjustment is based on the ratio of residents to average daily census. The hospital split bill, adjustment bill, waiver of liability and remaining guidelines that have historically been applied to operating payments also apply to capital payments under PPS.

B - Hospitals and Units Excluded

The following hospitals and distinct part hospital units (DPU) are excluded from PPS and are paid on a reasonable cost or other basis:

- Pediatric hospitals whose inpatients are predominately under the age of 18. Provider numbers are in the 3300-3399 range.
- Hospitals located outside the 50 States. ~~and the District of Columbia.~~
- Hospitals participating in a CMS-approved demonstration project or State payment control system.
- Nonparticipating hospitals furnishing emergency services have not been affected by the PPS statute (P.L. 97-21). They are paid under their existing basis.

When benefits are exhausted and the hospital bills ancillary services that are rendered in a DPU, it must show the S, T, U, V, W, or Y in the third position of its provider number.

The following illustrate billing where services are provided under PPS and in a DPU:

EXAMPLE 1

A beneficiary is admitted to provider number 00-0001 (a swing-bed hospital) on January 1, and on January 6 begins to receive SNF level services and is discharged on January 12. There are two admission dates and two discharge dates as follows:

- From 00-0001 with an admission date of 01/01, a from date of 01/01, and a discharge date of 01/06.
- From 00-U001 with an admission date of 01/06, a from date of 01/06, and a discharge date of 01/12.

EXAMPLE 2

A beneficiary is admitted to a hospital January l and on January 6 is transferred to the psychiatric unit, and discharged on January 12. There are two admission dates and two discharge dates as follows:

- From 00-0001 with an admission date of 01/01, a from date of 01/01, and a discharge date of 01/06.
- From 00-S001 with an admission date of 01/06, a from date of 01/06, and a discharge date of 01/l2.

(Handle a change from 00-0001 to 00-T001 as in Example #2.)

C - Situations Requiring Special Handling

1 - Sole Community Hospitals are paid in accordance with the methods used to establish the operating prospective rates for the first year of the PPS transition for

operating costs. The appropriate percentage of hospital-specific rate and the Federal regional rate is applied by the Pricer program in accordance with the current values for the appropriate fiscal year.

2 - Hospitals have the option to continue to be reimbursed on a reasonable cost basis subject to the target ceiling rate or to be reimbursed under PPS if the following are met:

- Recognized as of April 20, 1983, by the National Cancer Institute as Comprehensive Cancer Centers or Clinical Research Centers;
- Demonstrating that the entire facility is organized primarily for treatment of, and research on, cancer; and
- Having a patient population that is at least 50 percent of the hospital's total discharges with a principal diagnosis of neoplastic disease.

The hospital makes this decision at the beginning of its fiscal year. The choice continues until the hospital requests a change. If it selects reasonable cost subject to the target ceiling, it can later request PPS. No further option is allowed.

3 - Regional and national referral centers within short-term acute care hospital complexes. Rural hospitals that meet the criteria have their prospective rate determined on the basis of the urban, rather than the rural, adjusted standardized amounts, as adjusted by the applicable DRG weighting factor and the hospital's area wage index.

4 - Hospitals in Alaska and Hawaii have the nonlabor related portion of the wage index adjusted by their appropriate cost-of-living factor. These calculations are made by the Pricer program and are included in the Federal portion of the rate.

5 - Kidney, heart, and liver acquisition costs incurred by approved Transplant Centers are treated as an adjustment to the hospital's payments. These payments are adjusted in each cost reporting period to compensate for the reasonable expenses of the acquisition and are not included in determining prospective payment.

6 - Religious Nonmedical Health Care Institutions are paid on the basis of a predetermined fixed amount per discharge. Payment is based on the historical inpatient operating costs per discharge and is not calculated by "Pricer."

7 - Transferring hospitals with discharges assigned to DRG 385 (Neonates, Died or Transferred) or DRG 504-511 (burns, transferred to another acute care facility) have their payments calculated by the Pricer program on the same basis as those receiving the full prospective payment. They are also eligible for cost outliers.

8 - Nonparticipating hospitals furnishing emergency services are not included in PPS.

9 - Veterans Administration (VA) Hospitals are generally excluded from participation. Where payments are made for Medicare patients, the payments are determined in accordance with 38 U.S.C. 5053(d).

10 - A hospital that loses its urban area status as a result of the Executive Office of Management and Budget redesignation occurring after April 20, 1983 may qualify for special consideration by having its rural Federal rate phased-in over a

2-year period. The hospital will receive, in addition to its rural Federal rate in the first cost reporting period, two-thirds of the difference between its rural Federal rate and the urban Federal rate that would have been paid had it retained its urban status. In the second reporting period, one-third of the difference is applied. The adjustment is applied for two successive cost reporting periods beginning with the cost-reporting period in which CMS recognizes the reclassification.

11 - The payment per discharge under the PPS for hospitals in Puerto Rico is the sum of:

- 50 percent of the Puerto Rico discharge weighted urban or rural standardized rate.
- 50 percent of the national discharge weighted standardized rate.

(The special treatment of referral centers and sole community hospitals does not apply to prospective payment hospitals in Puerto Rico.)

There are special criteria that facilities must meet in order to obtain approval for payment for heart transplants and special processing procedures for these bills. (See §90.2.) Facilities that wish to obtain coverage of heart transplants for their Medicare patients must submit an application and documentation showing their initial and ongoing compliance with the criteria. For facilities that are approved, Medicare covers under Part A all medically reasonable and necessary inpatient services.

12 - Hospitals with high percentage of ESRD discharges may qualify for additional payment. These payments are handled as adjustments to cost reports.

13 - Exception payments are provided for hospitals with inordinately high levels of capital obligations. They will expire at the end of the 10-year transition period. Exception payments ensure that for FY 1992 and FY 1993:

- Sole community hospitals receive 90 percent of Medicare inpatient capital costs:
- Urban hospitals with 100 or more beds and a disproportionate share patient percentage of at least 20.2 percent receive 80 percent of their Medicare inpatient capital costs; and
- All other hospitals receive 70 percent of their Medicare inpatient capital costs.

A limited capital exception payment is also provided during the 10-year capital transition period for hospitals that experience extraordinary circumstances that require an unanticipated major capital expenditure. Events such as a tornado, earthquake, catastrophic fire, or a hurricane are examples of extraordinary circumstances. The capital project must cost at least $5 million to qualify for this exception.

D - DRG Classification

The DRGs are a patient classification system which provides a means of relating types of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Payment for inpatient hospital services is made on the basis of a rate per discharge that varies according to the DRG to which a beneficiary's stay is assigned. All inpatient transfer/discharge bills from both PPS and non-PPS facilities, including those from

waiver States, long-term care facilities, and excluded units are classified by the Grouper software program into one of 489 diagnosis related groups (DRGs).

The following DRGs receive special attention:

- **DRG No. 468** - Represents a discharge with valid data but where the surgical procedure is unrelated to the principal diagnosis. This DRG has a weight assigned and will be paid. The hospital must review the record on each DRG in the remittance record and where either the principle diagnosis or surgical procedure was reported incorrectly, prepare an adjustment bill. The FI may elect to avoid the adjustment bill by returning the bill to the hospital prior to payment. Further, Quality Improvement Organizations (QIOs) will review all DRG 468 cases.
- **DRG No. 469** - Represents a discharge with a valid diagnosis in the principle diagnosis field, but one not acceptable as a principal diagnosis. Examples include a diagnosis of diabetes mellitus or an infection of the genitourinary tract during pregnancy, both unspecified as to episode of care. These diagnoses may be valid, but they are not sufficient to determine the principal diagnosis for DRG assignment purposes. FIs will return the claims. The hospital must enter the corrected principal diagnosis for proper DRG assignment and resubmit the claim.
- **DRG No. 470** - Represents a discharge with invalid data. FIs return the claims for correction of data elements affecting proper DRG assignment. The hospital resubmits the corrected claim.

When the bills are processed in conjunction with the MCE (see §20.2.1) coding inconsistencies in the information and data are identified.

The MCE must be run before Grouper to identify inconsistencies before the bills are processed through the Grouper.

E - Difference in Age/Admission Versus Discharge

HO-415.4

When a beneficiary's age changes between the date of admission and date of discharge, the DRG and related payment amount are determined from the patient's age at admission.

40.3 - Outpatient Services Treated as Inpatient Services

(Rev. 156, 04-30-04)

A3-3610.3, HO-415.6, HO-400D, A-03-008, A-03-013, A-03-054

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 FIs 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 PPS, services are shown on the bill and included in the Part A payment. See Chapter 1 for FI 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 operated by the hospital (or by another entity under arrangements with the hospital), within 3 days prior to 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, services provided by the hospital on Sunday, Monday, or Tuesday are included in the inpatient Part A payment. This provision does not apply to ambulance services. (See the Medicare Benefit Policy Manual, Chapter 10.)

This provision does not apply to providers subject to LTCH PPS or IRF PPS.

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (PPS) as well as those hospitals and units excluded from PPS. For services provided on or after October 31, 1994, for hospitals and units excluded from PPS, this provision applies only to services furnished within one day prior to the date of the beneficiary's admission.

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

0254 -	Drugs incident to other diagnostic services

	diagnostic services
0255 -	Drugs incident to radiology
030X -	Laboratory
031X -	Laboratory pathological
032X -	Radiology diagnostic
0341 -	Nuclear medicine, diagnostic
035X -	CT scan
040X -	Other imaging services
046X -	Pulmonary function
048X -	Cardiology, with HCPCS codes 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544 - 93552, 93561, or 93562
053X -	Osteopathic services
061X -	MRT
062X -	Medical/surgical supplies, incident to radiology or other diagnostic services
073X -	EKG/ECG
074X -	EEG
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 a PPS or an 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 PPS, CWF will reject outpatient diagnostic bills that occur on

the day of or one day before admission. For PPS hospitals, CWF will continue to reject outpatient diagnostic bills for services that occur on any of the 3 days prior to admission.

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)

Nondiagnostic outpatient services that are related to a patient's hospital admission and that are provided by the hospital, or by an entity wholly owned or operated by the hospital (or by another entity under arrangements with the hospital), to the patient during the 3 days immediately preceding the date of the patient's admission are deemed to be inpatient services and are included in the inpatient payment. This provision applies only when the patient has Part A coverage.

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

LTCH PPS providers and IRF PPS providers are not subject to the 3-day payment widow (72-hour rule) for pre-admission services.

This provision does not apply to ambulance services. (See the Medicare Benefit Policy Manual, Chapter 10.) For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient (PPS) as well as those hospitals and units excluded from PPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from PPS, this provision applies only to services furnished within 1 day prior to the date of the beneficiary's admission. Preadmission services are related to the admission if they are

furnished in connection with the principal diagnosis that necessitates the patient's admission as an inpatient (i.e., if the outpatient principal diagnosis is the same as the inpatient principal diagnosis). 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 FI will 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.

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev. 156, 04-30-04)

141 – Maryland Waiver Hospitals

(Rev. 156, 04-30-04)

In accordance with Section 1814 (b) (3) of the Act, services provided by hospitals in Maryland subject to the Health Services Cost Review Commission (provider numbers 210001 - 210099, 212005, and 212007) are paid according to the terms of the waiver, that is 94% of submitted charges subject to any unmet Part B deductible and coinsurance. Payment should not be made under a fee schedule or other payment method for outpatient items and services provided except the following situations:

- *Reference laboratory services which are paid under the clinical diagnostic laboratory fee schedule (bill type 14X), and*

- *Ambulance services which are subject to the ambulance fee schedule.*