CMS Manual System

Pub 100-04 Medicare Claims Processing

Transmittal 714

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: OCTOBER 21, 2005

Change Request 4089

SUBJECT: Payment Window Edit Corrections within the Common Working File (CWF)

I. SUMMARY OF CHANGES: It was recently determined that one of the revenue codes used in editing for the payment window was never implemented correctly since 1991. Revenue code 048X should only be bundled on the inpatient bill with certain specified HCPCS codes. Also, in terms of the one day pay window, CWF is editing for an exact match of provider numbers. However, the provider numbers will not match exactly when the hospital is a distinct part unit of a hospital, so CWF has not been editing appropriately in this scenario. Therefore, we will modify the edit to bundle with provider numbers with an 'S', 'T', 'R', or 'M' in the third digit of the provider number. CMS will also use this opportunity to clean up the manual section.

NEW/REVISED MATERIAL

EFFECTIVE DATE: April 1, 2006

IMPLEMENTATION DATE: April 3, 2006

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
R	3/40.3/Outpatient Services Treated as Inpatient Services

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 714	Date: October 21, 2005	Change Request 4089

SUBJECT: Payment Window Edit Corrections within the Common Working File (CWF)

I. GENERAL INFORMATION

A. Background: It was recently determined that one of the revenue codes used in editing for the payment window was never implemented correctly. Revenue code 048X should only be bundled with the inpatient bill with certain specified HCPCS codes. Also, in terms of the one day pay window, CWF is editing for an exact match of provider numbers. However, the provider numbers will not match exactly when the hospital is a distinct part unit of a hospital, so CWF has not been editing appropriately in this scenario. Therefore, we will modify the edit to bundle with provider numbers with an 'S', 'T', 'R', or 'M' in the third digit of the provider number.

B. Policy: The payment window policy is long standing Medicare policy. Section 1886(a)(4) of the Social Security Act and the regulations at 42 CFR 412.2(c)(5) and 413.40(c)(2) define the operating costs of inpatient services under the prospective payment system to include certain preadmission services furnished by the admitting hospital (or by any entity wholly owned or wholly operated by the admitting hospital or by another entity under arrangements with the admitting hospital). Also see Chapter 3, Section 40.3 for more detail.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4089.1	The CWF shall modify the existing payment window edits to bundle Revenue Code 048X (Cardiology) only when present with the following HCPCS codes: 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544 – 93552, 93561 or 93562.								X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4089.2	The CWF shall modify the payment window edits to enforce the one-day payment window by looking at the third digit 'S', 'T', 'M', or 'R' of the provider number on the inpatient bill.								X	

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4089.3	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 Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X								X

IV. 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

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 1, 2006 **Implementation Date:** April 3, 2006 **Pre-Implementation Contact(s):** claims processing: Sarah Shirey at (410) 786-0187; policy: Valerie Miller at (410) 786-4535 **Post-Implementation Contact(s):** Appropriate Regional Office	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

40.3 - Outpatient Services Treated as Inpatient Services

(*Rev*. 714, Issued: 10-21-05, Effective: 04-01-06, Implementation: 04-03-06)

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 the hospital 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 *wholly* operated by the *admitting* hospital (or by another entity under arrangements with the *admitting* hospital), within 3 days prior to *and including* 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, *outpatient* services provided by the hospital on Sunday, Monday*,* Tuesday*, or Wednesday* are included in the inpatient Part A payment.

This provision does not apply to ambulance services *and maintenance renal dialysis services* (*s*ee the Medicare Benefit Policy Manual, Chapter*s* 10 *and 11, respectively*). *Additionally, Part A services furnished by skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.*

For services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital inpatient prospective payment system (*I*PPS) as well as those hospitals and units excluded from *I*PPS.

For services provided on or after October 31, 1994, for hospitals and units excluded from *I*PPS, this provision applies only to services furnished within one day prior to *and including* the date of the beneficiary's admission. *The hospitals and units that are excluded from IPPS are: psychiatric hospitals and units; inpatient rehabilitation facilities (IRF) and units; long-term care hospitals (LTCH); children's hospitals; and cancer hospitals.*

Critical access hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.

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
0255 -	Drugs incident to radiology
030X -	Laboratory
031X -	Laboratory pathological
032X -	Radiology diagnostic
0341 -	Nuclear medicine, diagnostic
035X -	CT scan
0371 -	*Anesthesia incident to Radiology*
0372 -	*Anesthesia incident to other diagnostic services*
040X -	Other imaging services
046X -	Pulmonary function
0471 -	*Audiology diagnostic*
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*n I*PPS or *IPPS*-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 *I*PPS, CWF will reject outpatient diagnostic bills that occur on the day of or one day before admission. For *I*PPS hospitals, CWF will continue to reject outpatient diagnostic bills for services that occur on *the day of or* 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 <u>On or After</u> 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 *wholly* operated by the *admitting* hospital (or by another entity under arrangements with the *admitting* hospital), to the patient during the 3 days immediately preceding *and including* the date of the patient's admission are deemed to be inpatient services and are included in the inpatient payment. *Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay. 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 shall 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. If there are both diagnostic and nondiagnostic preadmission services and the nondiagnostic services are unrelated to the admission, the hospital may separately bill the nondiagnostic preadmission services to Part B.* This provision applies only when the patient has Part A coverage. This provision does not apply to ambulance services *and maintenance renal dialysis. Additionally, Part A services furnished by*

skilled nursing facilities, home health agencies, and hospices are excluded from the payment window provisions.

For services provided before October 31, 1994, this provision applies to both hospitals subject to IPPS as well as those hospitals and units excluded from IPPS (see section B above).

For services provided on or after October 31, 1994, for hospitals and units excluded from IPPS, this provision applies only to services furnished within one day prior to and including the date of the beneficiary's admission.

Critical access hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.

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