

## HEALTH LAW UPDATE

NEWS FOR THE CLIENTS AND FRIENDS OF BASS, BERRY & SIMS PLC

### **Battening Down the 3-Day Payment Window Hatch: CMS Addresses New Statutory Provision**

**July 30, 2010**

On June 29, 2010, the Centers for Medicare & Medicaid Services (“CMS”) issued a one-page memorandum<sup>1</sup> explaining Section 102 of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (the “Act”).<sup>2</sup> Section 102 of the Act clarifies and amends Medicare’s policy for payment of hospital services within the so-called “3-day payment window.” This longstanding Medicare policy requires hospitals to include in their charges for inpatient stays all charges for diagnostic services, as well as all charges for non-diagnostic services “related to” the inpatient stay, which are provided by the hospital (or an entity wholly owned or operated by the hospital) on the date of the inpatient admission or during the 3-day period preceding the inpatient admission.

Historically, CMS has determined whether a particular outpatient service is “related” to the inpatient admission by looking at whether the ICD-9-CM diagnosis code for the outpatient service is the same as or different than the primary diagnosis of the inpatient admission.<sup>3</sup> If the ICD-9-CM diagnosis is the same as the primary inpatient diagnosis, CMS has historically considered the outpatient services as “related” and therefore bundled into the payment for the inpatient stay. Conversely, if the ICD-9-CM diagnosis is different than the primary inpatient diagnosis, CMS has historically allowed the hospital to bill separately for these services on the assumption that such services are “unrelated” to the inpatient admission.

Now, however, effective for hospital outpatient services provided on or after June 25, 2010, the Act stipulates that the term “other services related to the admission” includes *all* services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made by Medicare that are provided by a hospital (or by an entity wholly owned or operated by the hospital) to a patient on the date of the patient’s inpatient

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<sup>1</sup> Available at:

<http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3773&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date>

<sup>2</sup> Public Law No. 111-192 (June 25, 2010).

<sup>3</sup> See CMS Medicare Claims Processing Manual, Chapter 3, § 40.3(b)-(c).

admission or during the three days<sup>4</sup> immediately preceding the date of the admission *unless* “the hospital demonstrates (in a form and manner, and at a time specified by the [Department of Health and Human Services] Secretary) that such services are not related (as determined by the Secretary) to such admission.”<sup>5</sup> Effectively, the Act creates a presumption that all non-diagnostic outpatient services provided in the 3-day window are “related to” the inpatient admission and puts an affirmative duty on hospitals to demonstrate otherwise.

CMS is to issue instructions “in the very near future” for how hospitals are to bill for non-diagnostic services provided within the 3-day payment window, presumably including how to demonstrate sufficiently that hospital outpatient services are unrelated to an inpatient diagnosis (it is as yet unclear the extent to which hospitals will be able to use ICD-9-CM diagnosis codes in the future to demonstrate the “unrelated” nature of services). CMS notes that until instructions are issued, hospitals should include charges for all diagnostic services and for all non-diagnostic services that they believe meet the requirements of Act’s new provision. CMS states that if a hospital believes that a non-diagnostic service is “truly distinct from” and “unrelated to” the inpatient stay, the hospital may separately bill for the service (as long as the hospital has supporting documentation).<sup>6</sup> CMS cautions, however, that such separately billed service “may be subject to subsequent review.” Note that the Act makes no changes to billing for diagnostic services, so hospitals should continue to bundle all diagnostic services provided during the three days prior to the inpatient stay.

The Act provides that there shall be no administrative or judicial review of whether services provided prior to a patient’s inpatient admission are related to the admission. The Act also prohibits Medicare from reopening, adjusting, or making payment on new claims submitted for outpatient non-diagnostic services provided prior to June 25 that were previously bundled into an inpatient claim (and for which the request for reopening, adjustment, or payment was not submitted prior to June 25).

If you have any questions about this *Health Law Update*, please contact any of the attorneys in our Healthcare Practice Group listed below.

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<sup>4</sup> In the case of a hospital that is not a “subsection (d) hospital,” the relevant period is one day preceding admission, not three. A hospital is generally not a subsection (d) hospital if it is excluded from the inpatient prospective payment system (IPPS). See 42 U.S.C. § 1395ww(d)(1)(B).

<sup>5</sup> Public Law No. 111-192 (June 25, 2010).

<sup>6</sup> CMS does not elaborate on what types of documentation would support that a service is “truly distinct” from an inpatient stay. Hopefully, the soon-to-be-issued instructions will provide guidance in this regard.

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