Outpatient Services Prior to Inpatient Admission

CARC 96 and RARC M2

Policy: Medicaid Provider Manual (MPM) Chapter "Billing and Reimbursement for Institutional Providers" Section 7.22 Preadmission Diagnostic Services

MPM Chapter "Hospital" Section 3.25 Preadmission Diagnostic Services

MSA Policy Bulletin MSA 10-60

L-Letter 14-53 and L-Letter 14-25

Medicare Learning Network (MLN) MM7502

In June 2010, CMS made changes to the 3-day payment window policy. Previous policy required that hospitals include all diagnostic services provided within the 3-day window (or 1 day). This was amended to now also include non-diagnostic services. Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include the following on the claim for a beneficiary's inpatient stay: diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the beneficiary during the 3-day (or 1-day) payment window.

The 3-day payment window applies to services provided on the date of admission and the 3 calendar days preceding the date of admission that will include the 72-hour period that immediately precedes the time of admission but may be longer than 72 hours because it is a calendar day policy. The 1-day payment window applies to the date of admission and the entire calendar day preceding the date of admission and will include the 24-hour period that immediately preceded the time of admission but may be longer than 24 hours.

Hospitals subject to the 1-day payment window (when Medicare is the primary payer):

- Psychiatric hospitals and units
- Inpatient rehabilitation hospitals and units
- Long term care hospitals
- Children's hospitals
- Cancer hospitals

Services excluded from the 3- day (or 1-day) window:

- Ambulance
- Maintenance renal dialysis

Providers can attest that the Outpatient and Inpatient claims are not related by appending the appropriate condition code on the outpatient claim. The clinical documentation must support that the outpatient services are not clinically associated with the inpatient stay. Providers must specifically document that they are treating an unrelated condition.

Example of unrelated visit not included in the inpatient stay:

> Patient is scheduled for an inpatient surgery on Tuesday. The day before the surgery, patient slips and falls breaking their wrist. The patient presents to the ER for treatment of the wrist fracture on Monday and is then admitted Tuesday for the planned surgery. The outpatient visit is not related, and the appropriate coding should be appended to the outpatient claim to attest that the visits are unrelated.

Example of a related admission included in the inpatient stay:

> Patient presents to the ER after falling and breaking their wrist. The patient is treated and discharged and given pain medication. The patient returns to the ER suffering chest pain and is admitted. Although these visits are most likely clinically unrelated, they would have to be combined since all the outpatient services were provided on the day of the inpatient admission.

Billing Tips:

- When billing an inpatient claim within the 3-day (or 1-day) window, the from/through dates should be the actual treatment dates and the date of admission should be the date the physician signed the order to admit the patient. Therefore, the admit date and the from date may not be the same.

- If a claim is suspended or denied for the 3 day or 1-day window, the Claim Limit List function in CHAMPS.