MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 10-60

Distribution: Hospitals

Issued: December 1, 2010

Subject: Preadmission Diagnostic Services – Three Day (or one day) Payment Window - Outpatient Services Treated as Inpatient Services

Effective: January 1, 2011

Programs Affected: Medicaid, Children's Special Health Care Services, Maternity Outpatient Medical Services, Adult Benefits Waiver

The Michigan Department of Community Health (MDCH) is implementing the Centers for Medicare & Medicaid Services (CMS) three day payment window policy for outpatient services treated as inpatient, with a few exceptions, for all Medicaid enrolled hospitals. The new policy will be effective for dates of service (DOS) on and after January 1, 2011. Providers are advised to follow uniform billing guidelines to comply and facilitate coordination of benefits (COB) and relieve administrative burden with processing institutional crossover claims for Medicaid adjudication.

Clarification of Services

On June 25, 2010, regulatory changes were signed into law by the President under the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010," Pub. L. 111-192. The new law impacted the interpretation of the long standing Medicare three-day payment policy. Medicare's payment policy applies to hospital services provided in outpatient hospital departments on the day of or during the non-diagnostic services (other than maintenance renal dialysis services and ambulance) three days prior to an inpatient admission. Before the change, Medicare's three-day rule required hospitals to bill all diagnostic services rendered within three days of admission and all 'related' non-diagnostic services to the inpatient admission as part of the inpatient stay.

The recent regulatory change makes the CMS policy regarding admission-related outpatient non-diagnostic services consistent with hospital uniform billing practices. The new clarification of services 'related to the admission' includes non-diagnostic outpatient services (other than maintenance renal dialysis services and ambulance) that are: (1) rendered on the date of inpatient hospital admission, or (2) rendered in the three days prior to inpatient hospital admission, unless the hospital can document that the non-diagnostic services are unrelated.

In July 2010, CMS further clarified 'related/unrelated' in their inpatient prospective payment system (IPPS) final rule. All non-diagnostic services rendered on the date of inpatient admission and all services rendered within three calendar days preceding inpatient admission are "deemed related to the inpatient admission and all services must be billed with the inpatient stay/bill." Hospitals must bundle the outpatient diagnostic services (including diagnostic clinical laboratory tests) or other services related to the hospital admission during the payment window. CMS will provide timely updates to their billing chapter with additional billing instructions (i.e., using a modifier, a condition code, etc).

Policy

Effective for DOS on and after January 1, 2011, MDCH will follow Medicare's policy for all preadmission diagnostic services and other preadmission services – outpatient services treated as inpatient with a few exceptions in compliance with the law.

All non-diagnostic services rendered in the three day window prior to the inpatient hospital admission may not be billed separately and must be bundled into the inpatient stay, unless the hospital can document they are unrelated services. CMS plans to implement a documentation process using a modifier, a condition code and/or other indicator for the three day (or one day) payment window. Hospitals will be required to maintain documentation in the beneficiary's medical record to support that the outpatient preadmission non-diagnostic service(s) are unrelated to the inpatient admission (for the outpatient and/or inpatient claim). CMS will no longer use a matching ICD-9-CM diagnosis code.

Medicaid Exception

MDCH does not differentiate any specialty hospitals or facilities referenced in the CMS policy (i.e., critical access hospital [CAH], cancer, rehab, etc) and the new regulation will not apply to ambulance providers and free standing dialysis centers. MDCH will use a hospital's tax identification number to align with CMS's definition of "any hospital entity that is wholly owned or wholly operated by" the hospital. Otherwise, MDCH will align as closely as possible with the Medicare policy and guidelines for all beneficiaries.

Billing Instructions

MDCH policy/billing guidelines align with billing guidance referenced in the Medicare Claims Processing Manual Pub 100-4, Chapter 3 and the applicable section (i.e., date specific) for "Outpatient Services Treated as Inpatient Services." For additional billing information, Medicare is to provide (when available) regulation updates to the Medicare Claims Processing Chapter 3, Outpatient Services Treated as Inpatient Services for further billing details. CMS will also provide timely updates to the Medicare regulations and Medicare Claims Processing Manual.

Manual Maintenance

Retain this bulletin until applicable information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

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