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Clarifying Changes Expand the Scope of the Medicare Three-Day Payment Window

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On August 18, 2011, the Centers for Medicare & Medicaid Services (CMS) published the final rule implementing Section 102 of The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, which clarified the application of Medicare's "three-day payment window" to certain outpatient services. The Medicare 72-hour rule, as it's commonly known, requires an IPPS hospital (or its wholly-owned or operated entity) to bill any charges for outpatient diagnostic services or “other services related to [the patient's] admission” that are provided during the three days preceding the hospital admission, as part of the inpatient claim. This three-day payment window has been in effect for many years, but the lack of clarity regarding what constitutes “other services” limited the rule’s application to diagnostic services.

In response to this confusion, Section 102 clarified that outpatient non-diagnostic services are included in the “other services” category and are “admission-related” if they are clinically associated with the reason for the inpatient admission (irrespective of whether the outpatient and inpatient diagnoses are the same). Moreover, all outpatient non-diagnostic services rendered within the three-day window now will be deemed related to the admission *unless* the hospital attests that specific non-diagnostic outpatient services are clinically distinct and unrelated to the hospital claim.

In addition to describing the expansive scope of services subject to the three-day payment window, CMS emphasized that the rule also applies to services rendered at hospital-owned or operated physician clinics or practices. Any clinic or practice wholly-owned or operated by the admitting hospital is subject to the three-day payment window, and the technical portion of preadmission

services must be included on the inpatient bill. The physician's professional services may be billed separately, and are not subject to the three-day payment window. CMS expects to issue a future proposal to implement the new billing provisions for clinics and practices. Hospitals should anticipate that any subsequent proposal will include an expectation that hospitals inform physician clinics and offices when an inpatient admission occurs.

What This Means to You

Hospitals impacted by the rule change are advised to consider implementing a process to identify and isolate outpatient services that are related to a subsequent admission for purposes of the inpatient claim. Institutions wishing to attest that a non-diagnostic outpatient service is unrelated to an inpatient claim must add the new condition code 51 to the preadmission claim. In addition, adequate medical documentation should always be available in the patient's file to support the attestation. Any wholly-owned or operated physician clinics and practices are advised to implement an effective communication system to ensure that services subject to the three-day payment window can be identified and billed properly.

Contact Info

Contact your Husch Blackwell attorney or Cori Turner at 816.983.8376 if you have any questions about this clarifying change or any other healthcare matters.

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