

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – In September 2012, the Centers for Medicare & Medicaid Services (CMS) announced the availability of a new electronic mailing list for those who refer Medicare beneficiaries for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Referral agents play a critical role in providing information and services to Medicare beneficiaries. To ensure you give Medicare patients the most current DMEPOS Competitive Bidding Program information, CMS strongly encourages you to review the information sent from this new electronic mailing list. In addition, please share the information you receive from the mailing list and the link to the [“mailing list for referral agents”](#) subscriber webpage with others who refer Medicare beneficiaries for DMEPOS. Thank you for signing up!

MLN Matters® Number: MM8046

Related Change Request (CR) #: CR 8046

Related CR Release Date: January 31, 2013

Effective Date: July 1, 2013

Related CR Transmittal #: R11690TN

Implementation Date: July 1, 2013

Modification of Payment Window Edit in the Common Working File (CWF) to Modify Diagnostic Service List

Provider Types Affected

This MLN Matters® Article is intended for certain hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for diagnostic services (including clinical diagnostic laboratory tests services) to Medicare beneficiaries.

What You Need to Know

This article, based on Change Request (CR) 8046, informs you that the Centers for Medicare & Medicaid Services (CMS) will modify the payment window edit in Medicare's Common Working File (CWF) to update the diagnostic service list. Currently, CWF looks at a listing of diagnostic services that contains terminated or revised Healthcare Common Procedure Coding System (HCPCS) codes. This CR will modify the list to allow CWF to edit diagnostic services correctly. Effective April 1, 2013, CR8049 includes in the diagnostic payment window edits HCPCS codes 93451-93464, 93503, 93505,

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.

93530-93533, 93561-93568, 93571-93572, G0275, and G0278 submitted for revenue codes 0481 and 0489. Make sure that your billing staffs are aware of this update.

Background

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 services provided before October 31, 1994, this provision applies to both hospitals subject to the hospital Inpatient Prospective Payment System (IPPS) as well as those hospitals and units excluded from IPPS.

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. 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.

This provision does not apply to ambulance services and maintenance renal dialysis. Additionally, Part A services furnished by Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and hospices are excluded from the payment window provisions.

The 3-day (or 1-day) payment window policy does not apply when the admitting hospital is a Critical Access Hospital (CAH). Also, the 3-day (or 1-day) payment window policy does not apply to outpatient diagnostic services included in the Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) all-inclusive rate.

Additional Information

The official instruction, CR8046, issued to your FI and A/B MAC regarding this change, may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R11690TN.pdf> on the CMS website.

If you have any questions, please contact your FI or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2011 American Medical Association.