

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



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- [“Medicare Learning Network® Suite of Products and Resources for Inpatient Hospitals”](#), Educational Web Guide, ICN 905704, Downloadable

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Pre-admission Diagnostic Testing Review

Provider Types Affected

This MLN Matters® Special Edition is intended for inpatient hospitals submitting claims to Medicare contractors (Fiscal Intermediaries (FIs) and A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

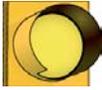


STOP – Impact to You

This article is to inform you that the Recovery Auditors have identified pre-admission diagnostic testing services being reimbursed in addition to reimbursement of the Inpatient Prospective Payment System (IPPS) Hospital for services provided during the defined temporal window as a source of overpayments.

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CAUTION – What You Need to Know

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or 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.

- The technical portion of all services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and therefore, must be included on the bill for the inpatient stay.
- The technical portion of outpatient services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the first, second, and the third calendar days (1 calendar day for a non-subsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless these services are unrelated to the inpatient hospital claim (that is, these preadmission services are clinically distinct or independent from the reason for the beneficiary's inpatient admission).



GO – What You Need to Do

Make sure that your billing staffs are aware of these billing requirements in order to avoid billing errors that may lead to overpayments.

Background

Medicare Policy

Section 102(a)(1) of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) provides that, for outpatient services furnished on or after June 25, 2010, the technical portion of all services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and thus, must be included on the bill for the inpatient stay.

Also, the technical portion of outpatient services that are not diagnostic, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or operated by the hospital) on the first, second, and the third calendar days (1 calendar day for a non-subsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, unless these services are unrelated to the inpatient hospital claim (that is, these preadmission services are clinically distinct or independent from the reason for the beneficiary's inpatient admission).

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Claims Examples

Example 1: An outpatient claim was submitted for CPT codes 36415 - Routine Venipuncture; 80053 - Comprehensive Metabolic Panel; 86304 - Immunoassay, Tumor, CA 125; 83725 - Assay of Magnesium; and 85025 - Complete CBC w/auto diff WBC for Date of Service (DOS) 2/18/2011. The patient was also admitted to inpatient with the same DOS, 2/18/2011. The admitting diagnostic codes were 183.0 Malignant Neoplasm Ovary and V58.11 Antineoplastic Chemotherapy and Immunotherapy.

Finding: Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or 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 example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

Example 2: An outpatient claim was submitted for CPT codes 36415 - Routine Venipuncture; 80053 - Comprehensive Metabolic Panel; 83615 - Lactate (LD) (LDH) Enzyme; 85025 - Complete CBC w/auto diff WBC; 86850 - RBC Antibody Screen; 86900 - Blood typing ABO; 86901 - Blood Typing RD (D); and 86923 - Compatibility Test for DOS 3/15/2011. The patient was admitted to inpatient on the following day, 3/16/2011. The admitting diagnostic codes were 285.9 Anemia NOS and 162.8 Malignant Neoplasm Bronchus or Lung NEC.

Finding: When a beneficiary receives outpatient hospital services during the day immediately preceding the hospital admission, the outpatient hospital services are treated as inpatient services if the beneficiary has Part A coverage. Hospitals and FIs apply this provision only when the beneficiary is admitted to the hospital before midnight of the day following receipt of outpatient services. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day.

When this provision applies, services are included in the applicable PPS payment and not billed separately. When this provision applies to hospitals and units excluded from the hospital PPS, services are shown on the bill and are included in the Part A payment.

Where to Read About this Policy

The "Medicare Claims Processing Manual," Chapter 3 - Inpatient Hospital Billing, Section 40.3 - Outpatient Services Treated as Inpatient Services, which is available at

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf> on the CMS website, states:

"Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or 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

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payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.”

“This provision does not apply to ambulance services and maintenance renal dialysis services (see the “Medicare Benefit Policy Manual,” Chapters 10 and 11, respectively). Additionally, Part A services furnished by Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs), and hospices are excluded from the payment window provisions.”

“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.”

“Critical Access Hospitals (CAHs) are not subject to the 3-day (nor 1-day) DRG payment window.”

“An entity is considered to be “wholly owned or operated” by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facilities routine operations), regardless of whether it also has the authority to make the policies.”

Additional Information

If you have any questions, please contact your Medicare contractor at their toll-free number, which is available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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