

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



**News Flash** – A new publication titled “Mental Health Services” is now available in downloadable format from the Medicare Learning Network® at [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mental\\_Health\\_Services\\_ICN903195.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Mental_Health_Services_ICN903195.pdf) on the Centers for Medicare & Medicaid Services (CMS) website. This booklet is designed to provide education on mental health services, including covered mental health services, mental health services that are not covered, mental health professionals, outpatient psychiatric hospital services, and inpatient psychiatric hospital services.

MLN Matters® Number: MM7142 **Revised**

Related Change Request (CR) #: 7142

Related CR Release Date: October 29, 2010

Effective Date: June 25, 2010

Related CR Transmittal #: R796OTN

Implementation Date: April 4, 2011

### **Clarification of Payment Window for Outpatient Services Treated as Inpatient Services**

Note: This article was updated on December 11, 2012, to reflect current Web addresses. This article was previously revised on May 17, 2011, to correct a date on page 2. The correct date for processing adjustments for impacted claims is after April 4, 2011. All other information remains the same.

#### **Provider Types Affected**

This article is for Inpatient Acute Care hospitals that bill Medicare fiscal intermediaries (FIs) or Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

#### **Provider Action Needed**

Make sure your billing staff is aware of the following changes to the Medicare policy for payment of outpatient services on either the date of an inpatient admission or

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during the three calendar days immediately preceding an inpatient date of admission. These changes impact dates of service on or after June 25, 2010.

## Background

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Section 102 of the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010" pertains to Medicare's policy for payment of outpatient services provided on either the date of a beneficiary's inpatient admission or during the three calendar days immediately preceding the date of a beneficiary's inpatient admission to a "subsection (d) hospital" subject to the inpatient prospective payment system (or during the one calendar day preceding the date of a beneficiary's inpatient admission to a non-subsection (d) hospital).

Under the 3-day payment window, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include, on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient nondiagnostic services provided during the payment window. The new law makes the policy pertaining to admission-related outpatient nondiagnostic services more consistent with common hospital billing practices.

All services other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital), provided on the same date of the inpatient admission are deemed related to the admission and are not separately billable.

Additionally, outpatient nondiagnostic services, other than ambulance services (as denoted by revenue code 054X on the claim line) and maintenance renal dialysis services (Type of Bill 072X or Type of Bill 13X with HCPCS code G0257 along with other dialysis service lines identified by revenue codes 0270, 0304, 0634, 0635 and/or 0636 on the same date as G0257), provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's admission are deemed related to the admission; and thus, must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the inpatient hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 to the separately billed outpatient non-diagnostic services claim.

Providers may submit outpatient claims with condition code 51 starting April 1, 2011. Outpatient claims processed prior to April 4, 2011, but with dates of service on or after June 25, 2010 may need to be adjusted by the provider if they were rejected by Medicare. Such adjustments should be made after April 4, 2011.

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The statute makes no changes to the existing policy regarding billing of diagnostic services. All diagnostic services provided to a Medicare beneficiary by a subsection (d) hospital subject to the inpatient prospective payment system (IPPS), or an entity wholly owned or operated by the hospital, on the date of the beneficiary's inpatient admission and during the 3 calendar days (1 calendar day for a non-subsection (d) hospital) immediately preceding the date of admission would continue to be required to be included on the bill for the inpatient stay.

## Additional Information

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The official instruction, CR 7142, issued to your FI or MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R796OTN.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

If you have any questions, please contact your FI or 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.

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