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New Law Significantly Impacts Hospital Billing Under The Three-Day Payment Window Rule

Effective for inpatient hospital services furnished on or after June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (Act) provides significant changes to Medicare's "Three-Day Payment Window," which requires bundling into the inpatient payment services provided in hospital outpatient departments on either the day of or during the three days prior to an inpatient admission. The change in law requires that a hospital include in its charges for an inpatient hospital stay all diagnostic services and non-diagnostic services provided during the three-day payment window that are "related" to the inpatient stay. Thus, the new law expands the prohibition against the unbundling of services and submission of claims seeking separate and additional Medicare payments. Under the new law, the provider has the burden of demonstrating that a non-diagnostic outpatient service was unrelated to the inpatient service for which the patient was admitted in a form and manner to be determined by the Secretary of Health and Human Services (HHS Secretary). Accordingly, hospitals must immediately familiarize themselves with and comply with this new requirement. [Click here](#) for a copy of the new law.

Prior to the Act, the Three-Day Payment Window required that all outpatient diagnostic and "related" non-diagnostic medical services provided to a Medicare beneficiary by the admitting hospital (or by an entity wholly owned or operated by the admitting hospital) within three days prior to the date of such beneficiary's hospital admission were deemed to be inpatient services, and were included (bundled) in the inpatient payment. The outpatient non-diagnostic services were "related to" the inpatient admission only when there was an exact match between the principal ICD-9-CM diagnosis code assigned for the preadmission services and the inpatient stay. Thus, hospitals could submit a separate outpatient claim for non-diagnostic services only if such services were not "related to" the patient's admission. In the event that hospitals incorrectly included unrelated outpatient non-diagnostic services on inpatient Medicare claims, CMS allowed the hospitals to unbundle the non-diagnostic services and submit separate bills for those unrelated outpatient claims.

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Section 102 of the Act prohibits a hospital from submitting separate Medicare outpatient non-diagnostic claims for “other services related to the admission” within three days of a patient’s admission, unless the hospital can prove that such outpatient non-diagnostic services are unrelated to the inpatient services in a form and manner to be determined by the HHS Secretary. The Act also prohibits a hospital from re-billing to correct previously submitted inpatient Medicare claims that contain unrelated outpatient non-diagnostic services as defined by the ICD-9-CM diagnosis coding system. Depending on the criteria established by the HHS Secretary, hospitals will be unable to unbundle the inpatient services from the non-diagnostic outpatient services provided within three days prior to the admission and submit a claims adjustment requesting separate Medicare payments from CMS.

In guidance issued on June 25, 2010, the Centers for Medicare and Medicaid Services stated that the law clarifies that the term “other services related to the admission” includes “all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made by” Medicare that are provided by a hospital to a patient: (1) on the date of the patient’s inpatient admission, or (2) during the three days (or in the case of a hospital that is not a subsection (d) hospital, during the one day) immediately preceding the date of admission unless the hospital demonstrates the services are not related to the admission. CMS further explained that the Act “prohibits Medicare from re-opening, adjusting or making payments when hospitals submit new claims or adjustment claims for services that were provided prior to [June 25, 2010] in order to separately bill outpatient non-diagnostic services.” [Click here](#) for a copy of the CMS fact sheet.

Action Steps

To ensure compliance with Medicare’s Three-Day Payment Window rule, a nationwide compliance enforcement action was instituted in 1995, with follow up activity since that date. Moreover, compliance with the Three-Day Payment Window is among the primary audit concerns of the Recovery Audit Contractors. Accordingly, to assure compliance hospitals must become familiar with and implement the Act’s Medicare billing requirements by reviewing their Medicare billing policies, anticipated regulations and revisions to the CMS Manual for Medicare Claims Processing.

For assistance in reviewing the changes to Medicare’s Three-Day Payment Window rule and how these changes may affect your hospital, please contact any member of the Health Care Department.

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