Network Notification

Date: June 17, 2011 **Number: OH-P-2011-31**
MI-P-2011-17

To: Ohio & Michigan Medicare Providers and
Michigan Medicaid Providers

From: CareSource

Subject: Three-day Payment Window for Outpatient Services Treated as Inpatient Services

Effective Date: April 1, 2011

Please note: The following policy impacts the CareSource Medicare Advantage Special Needs Plan (CareSource Advantage®) Providers in Ohio and Michigan. This policy also affects Michigan Medicaid Providers.

This policy supports the Centers for Medicare and Medicaid Service's (CMS) Transmittal 796 and MSA 10-60 related to the three-day payment window for outpatient services treated as inpatient services.

CMS Policy:

Under the three-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 member's inpatient stay:

- The diagnoses
- Procedures
- Charges for all outpatient diagnostic services
- Admission-related, outpatient, non-diagnostic services provided during the three-day payment window

The new law makes the policy pertaining to admission-related, outpatient, non-diagnostic services more consistent with common hospital billing practices. All services,

other than ambulance and maintenance renal dialysis services, provided by the hospital on the same date of the inpatient admission, are deemed related to the admission and are not billable separately.

Summary of CMS Policy:
Services done on an outpatient basis that are within one, two or three days calendar days prior to inpatient stay are considered part of the inpatient stay and should be billed as such on the claim submission. Please see further description of the CMS policy below.

Further Description of the CMS Policy:
Outpatient, non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital, on the first, second and third calendar days (first calendar day for non-subsection (d) hospitals) preceding the date of a member's admission are deemed related to the admission and must be billed with the inpatient stay.

> *Exception to the CMS Policy:* The hospital may attest to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission, non-diagnostic services are clinically distinct or independent from the reason for the member's admission) by adding a Condition Code 51.
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> *Definition of Condition Code 51:* Attestation of unrelated, outpatient, non-diagnostic services to the separately billed outpatient, non-diagnostic services claim.

Using Condition Code 51:
Providers may submit outpatient claims with Condition Code 51 starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010.

Outpatient claims with a date of service on or after June 25, 2010, that did not contain Condition Code 51 received prior to April 1, 2011, will need to be adjusted by the provider if they were rejected by FISS or CWF.

The statute makes no changes to the existing policy regarding billing of diagnostic services (see section 40.3(B) of Pub100-4, Chapter 3).

All diagnostic services provided to a Medicare beneficiary by a subsection (d) hospital subject to the Inpatient Prospective Payment System (or an entity wholly-owned or operated by the hospital) on the date of the member's inpatient admission and during the three calendar days (one calendar day for a non-subsection (d) hospital) immediately preceding the date of admission will still be included on the bill for the inpatient stay.

Michigan Medicaid Exception

The Michigan Department of Community Health (MDCH) does not differentiate any specialty hospitals or facilities referenced in the CMS policy (e.g., critical access hospital, cancer, rehab, etc.) and the new regulation will not apply to ambulance providers and free standing dialysis centers.

MDCH will use a hospital's tax identification number to align with CMS's definition of "any hospital entity that is wholly-owned or wholly-operated by" the hospital. Otherwise, MDCH will align as closely as possible with the Medicare policy and guidelines for all members.