

Congress Has Clarified Medicare's Policy For Payment Under The 3-Day DRG Payment Window

On June 25, 2010, President Obama signed into law the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, which contains a section clarifying the Medicare 3-day DRG payment window for hospitals, commonly referred to as the 3-Day Rule. The 3-Day Rule governs how hospital outpatient services provided on the three days prior to an inpatient admission are paid.

Prior to enactment of this new law, there had been some confusion in the hospital community as to the application of the 3-Day Rule to their billing operations. Under the Rule, non-diagnostic services provided by a hospital within three days of an inpatient admission could be separately billed to Medicare if those services were not "related to the admission." The Centers for Medicare and Medicaid Services ("CMS") interpreted the phrase "related to the admission" in regulation as those services that are furnished in connection with the principal diagnosis that requires the beneficiary to be admitted as an inpatient. In other various Medicare manuals and transmittals, CMS specifically defined "related to admission" as occurring only when there is an exact match (for all five digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission non-diagnostic services and the inpatient admission. Without that exact match on the diagnosis code, hospitals could bill non-diagnostic services separately to Medicare Part B under CMS's definition.

The new law expands the definition of "other services related to the admission" to include all non-diagnostic services provided by a hospital to a patient: (1) on the date of the patient's inpatient admission, or (2) during the 3 days (or in limited cases, during the 1 day) immediately preceding the date of admission, unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related to such admission. Thus, it is now clear that, as of June 25, 2010, all non-diagnostic service provided on the date of the patient's admission are considered "related to the admission" and not separately billable to Medicare Part B even if the diagnosis code for the service does not match the diagnosis code for the admission. It remains unclear, however, how hospitals are to determine whether non-diagnostic services rendered on the 3 days preceding the admission date are "not related to such admission."

CMS has indicated that "in the very near future" it will provide instructions to the hospital community advising them how to bill for related non-diagnostic services provided during the 3-day (or 1-day) payment window. Until such time, CMS has advised that hospitals should include on the inpatient claim charges for all diagnostic and non-diagnostic services that it believes were related to the admission, as defined by the new law. If a hospital believes that a non-diagnostic service is truly distinct from and unrelated to the inpatient stay under the new definition of "other services related to the admission," the hospital may separately bill for the service provided that it has documentation to support that the service is unrelated to the admission. Until CMS provides instructions, however, it is unclear if CMS's rule requiring an exact match in the principal diagnosis code for the inpatient stay and the primary code for the outpatient visit is still the determining factor to demonstrate whether the service is related to the admission.

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In addition to expanding the definition of “other services related to the admission,” we note that Medicare contractors are now prohibited from reopening, adjusting or making payments on new claims or adjustment claims for services that were provided prior to June 25, 2010. Thus, hospitals are now precluded from doing retrospective reviews and submitting claims for previously bundled non-diagnostic outpatient services that did not have an exact match of the ICD-9-CM codes that they were otherwise entitled to separately bill for under CMS’s prior interpretation of the 3-Day Rule.

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