DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

June 11, 2003

Mr. Richard Pollack
Executive Vice President
American Hospital Association
325 Seventh Street, N.W.
Washington, D.C. 20004

Dear Mr. Pollack:

I would like to take this opportunity to respond to the "model practice" questions that the AHA has written me about and that your staff raised with Leslie Norwalk and Tom Barker of my staff last year. I apologize for the delay in responding.

Following are responses to issues you raised:

Question 1: Clarification of which practitioner can order diagnostic tests in the inpatient or outpatient setting

The question you raised was whether the Centers for Medicare & Medicaid Services (CMS) can issue clear instructions to the fiscal intermediaries (FI) regarding a potential inconsistency between Transmittal 1725 (September 27, 2001) and 42 CFR § 410.32(a). You raised this question in the context of whether or not a radiologist (who is not the patient's attending physician) can order diagnostic tests directly or whether the radiologist would need to go back to the referring physician to change or order tests for a hospital inpatient or outpatient.

Response 1:

The rules on ordering of diagnostic tests, as set forth in 42 CFR 410.32(a), apply to tests provided to non-hospital patients and to clinical diagnostic lab tests furnished to patients of hospital outpatient departments. These rules do not apply to other diagnostic tests furnished to hospital outpatient department patients. These tests are subject to the requirements of 42 CFR § 410.28 and the hospital conditions of participation. These rules also do not apply to tests furnished to hospital inpatients, since Part 410 of title 42 of the Code of Federal Regulations only governs Part B benefits.

It is important to note that there may be separate State requirements and local contractor policies that may apply. You should also know that CMS is considering issuing further instructions to our contractors or amendments to the regulation to ensure that CMS contractors' interpretation is consistent with policy.

Question 2: Same day discharges and admissions

You presented the hypothetical of the hospital inpatient who is admitted to one hospital, discharged at a later date, and then on the day of discharge, admitted to a second hospital for a condition unrelated to the first admission. You asked whether CMS could issue a program memorandum instructing our contractors to install program logic that would not automatically result in either a denial of such a claim or payment for the first hospital stay as a transfer (i.e., on a per-diem basis). You also suggested several methods that might accomplish this result, including instructing the contractor to contact the first hospital or conduct a medical review of the first stay, and if, on determination that the first stay was unrelated to the second, pay the claim properly.

Response:

The edits in the standard system will give the discharging hospital a per diem payment. In the past, and since these are rare occurrences, the system changes the patient status code and gives the discharging hospital the per diem payment. When the hospital gives medically documented proof that they indeed discharged the patient, the FI will override the edits involved. Some FIs forward this situation to the Quality Improvement Organization (QIO) for review who will then instruct the FI that this was a discharge situation and not a transfer.

Although there are currently no claims processing instructions, CMS did a draft PM making changes to standard systems common working file (CWF) to allow these situations to be systematically overridden. The FIs all commented very strongly against not making this situation automatically overrideable and that the QIO or Medical Review departments had a handle on the situation.

We have also had Office of the Inspector General (OIG) reports in the past year asking CMS to pay close attention to discharge statuses and to ensure that providers correctly code these instances. OIG found numerous examples of inappropriate discharges, which caused CMS millions of dollars; we noted these in the Preamble to the Notice of Proposed Rulemaking for the Fiscal Year 2004 IPPS regulation. Based on the comments from our contractors and the OIG findings, we stopped work on the draft PM.

We asked one of our contractors in a large state to comment further on this issue. Here is how that fiscal intermediary responded:

"Our experience has been that this is a very infrequent occurrence. Providers who truly fit this situation submit authoritative documentation, which is reviewed and kept on file to prove the payment. If verified that the patient was discharge and not transferred, we are able to circumvent the edits as follows: if notified by the CWF alert 7531, we do not process the adjustment to change the patient status to a transfer; if notified by CWF edit

7111, we cancel the receiving hospital's claim, and resubmit the claim in chronological order. We ignore the 7531 subsequently generated.

The current procedure acts as a control to safeguard incorrect payments. By relying on a CWF edit only, the control is removed; the provider community will know how the edit functions and will be able to bypass with a simple change of admitting diagnosis."

Therefore, we believe that since there is a process in place to address this rare occurrence, we are not inclined to issue modifications to our systems at this time.

Question 3: Archived laboratory specimens

You asked if we could clarify the policy articulated in AB-02-129, that the date of service for archived laboratory specimens is considered to begin when the specimen is removed from archives.

Response 3:

We have stated the policy in PM AB-02-129 that the date of service is the date the specimen is removed from archives. We have had several requests for clarification regarding how long a specimen will be kept and considered as archived. We state in PM AB-02-134 that the exact time is up to the contractor but that we expect that it would be a long period.

We are in the process of publishing a notice for public comment on this subject. That notice is scheduled for October 2003 publication. The proposed notice would add a specific time period so that there would be national consistency. During the public comment period, hospitals will be encouraged to address any further issues related to this subject in need of clarification.

Question 4: Local Medical Review Policies (LMRP) in the Emergency Department (ED)

You presented some very detailed comments on the increasing problems with LMRPs in the ED and the potential conflicts between our advanced beneficiary notice (ABN) requirements and Emergency Medical Treatment and Active Labor Act (EMTALA). You asked if we would consider providing further guidance on this matter.

Response:

We believe that our recently published guide that explains the ABN process, and its associated decision tree for the use of ABNs in the Emergency Department, (especially where the application of an LMRP would result in the denial of payment for a particular test or procedure), answer the concerns raised during meetings with senior CMS policy leaders. The guide can be accessed from our web-site at: http://cms.hhs.gov/medlearn/abn-readers.pdf. The URL for the ABN brochure is: http://cms.hhs.gov/medlearn/abn_readers_lettersize_22703.pdf. We would also direct your attention to PM A-01-144 (September 2001), which allows for the presenting diagnosis code to be listed on the claim for laboratory tests performed in the Emergency Department. We also noted that any LMRP frequency limits will not apply in the ED.

If you believe that further guidance from us is necessary, please let us know.

Question 5: Diagnostic Related Groups (DRG) payment window

You raised a problem with our policy on the "72-hour window." In particular, you commented that, although our policy provides that any tests provided on an outpatient basis that are "related to" an inpatient admission must be bundled if the tests are performed within 24 (diagnostic) or 72 (non-diagnostic) hours of the inpatient admission, the phrase "related to" has never been defined. Therefore, you posit, contractors are bundling all services provided within the appropriate window, even if unrelated.

Response:

We have received several questions on this issue during our hospital forums on the application of the 3-day payment window when a patient is admitted as an inpatient to an acute hospital within the 3-day window with the diagnosis unrelated to any ancillary tests performed within the preceding three days.

In the February 11, 1998 *Federal Register*, (63 FR 6864), we state in the final rule entitled "Payment for Preadmission Services," that any outpatient diagnostic service provided by the admitting hospital, or an entity that is wholly owned or wholly operated by the admitting hospital, within 3 days of a patient's admission (1 day for IPPS excluded hospitals), is subject to the DRG window. Outpatient nondiagnostic (therapeutic) services are required to be bundled with the inpatient billing when the service is "related to the admission."

In that same rule, we define "related to the admission" as when there is an exact match (for all digits) between the principal diagnosis code assigned for both the outpatient nondiagnostic service and the inpatient stay. Also, recently, we published a PM that we

believe addresses these concerns. You can access the PM from our web site at http://cms.hhs.gov/manuals/pm_trans/A03013.pdf.

Finally, you raised other items with us during the meeting that we believe have since been resolved; these include the following:

- The modification of the PM that directs FIs to use Form Locater 76 (FL76) to assess the medical necessity of laboratory tests performed for separate payment for Outpatient Prospective Payment System observation to direct them to use FL76 to assess the medical necessity of all services.

- The November 2002 issuance of Transmittal A-02-120 titled, "Change in Requirements for Medicare Payment for Low Osmolar Contrast Material (LOCM) Under the Outpatient Prospective Payment System (OPPS)" offers further guidance to the contractors related to coverage guidelines for payment for LOCM. In addition, you may be interested in learning that we are in the process of preparing a series of FAQs to address other issues regarding billing for and the use of LOCM, especially in the critical access hospital setting. We hope to have those FAQs developed around the time that we finalize the Inpatient Prospective Payment System rule this summer.

I hope that this information is helpful and, again, I want to thank you and your staff's patience and effort in these matters.

Sincerely,

Thomas A. Scully
Administrator