Clarification and Correction of “Inpatient Hospital Claims to Include Outpatient Services Related to the Inpatient Admission Effective September 1, 2012”

Information posted August 24, 2012

This is a clarification and correction of an article titled “Inpatient Hospital Claims to Include Outpatient Services Related to the Inpatient Admission Effective September 1, 2012,” which was published on July 13, 2012, on this website. The following aspects of the Texas Medicaid implementation of Medicare’s three-day payment window policy are being clarified or corrected:

• An additional exception to the inpatient stay inclusion timeframe
• Outpatient charges included in the inpatient stay
• Outpatient claims for services unrelated to the inpatient admission

Additional Exception

In addition to the exceptions listed in the original article, professional services that are rendered in the inpatient hospital setting (place of service 3) during the inpatient stay are excluded from the payment windows and may be submitted and reimbursed separately from the inpatient admission.

Outpatient Charges Included in the Inpatient Stay

Professional and outpatient charges that are related to the client’s inpatient stay and rendered within the three-day payment window will not be reimbursed separately. The claim for the inpatient stay should include charges for all services that are rendered by the facility as part of that inpatient stay.


Outpatient Hospital Institutional Claims for Services Unrelated to the Inpatient Admission

The original article indicated that outpatient claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the principal diagnosis code that is on the outpatient claim to the principal inpatient diagnosis. The outpatient services must be submitted with modifier U4 if the services are unrelated and the principal outpatient diagnosis is a three-digit match to the principal inpatient diagnosis.

The clarification is that the principle diagnosis code on an outpatient hospital claim is the diagnosis code that is referenced to the detail line item. Outpatient hospital claims for non-diagnostic services that are unrelated to the inpatient admission will be identified by comparing the referenced diagnosis code that is on the outpatient claim to the principal inpatient diagnosis.
The correction is that outpatient services that are submitted on the outpatient hospital institutional claim must be submitted with condition code 51 if the services are unrelated and the principal outpatient diagnosis is a three-digit match to the principal inpatient diagnosis. Modifier U4 must not be submitted on the outpatient hospital institutional claim to indicate a related service.

**Note:** Professional services (other than those rendered in the inpatient hospital setting) must be submitted with modifier U4 if the services are unrelated and the referenced professional diagnosis is a three-digit match to the principal inpatient diagnosis.

For more information, call the TMHP Contact Center at 1-800-925-9126.