NGS MU
NGSMEDICARE UNIVERSITY
MEANINGFUL • INFORMATIVE • SIMPLIFIED EDUCATION

National Government Services

NGSMedicare University Virtual Conference

Medicare 2021
A Journey to a Healthier Future and Partnership

A Peek Inside The Three-Day Payment Window for Acute Care Hospitals

5/12/2021

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

- Christine Janiszcak
  - Provider Outreach and Education, Consultant
- Jean Roberts, RN, BSN, CPC
  - Provider Outreach and Education, Consultant
- Pat Zachmann
  - Provider Outreach and Education, Consultant

Disclaimer

National Government Services, Inc. has produced this material as an informational reference for providers furnishing services in our contract jurisdiction. National Government Services employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this material. Although every reasonable effort has been made to assure the accuracy of the information within these pages at the time of publication, the Medicare Program is constantly changing, and it is the responsibility of each provider to remain abreast of the Medicare Program requirements. Any regulations, policies and/or guidelines cited in this publication are subject to change without further notice. Current Medicare regulations can be found on the CMS website.

No Recording

- Attendees/providers are **never** permitted to record (tape record or **any** other method) our educational events
  - This applies to our webinars, teleconferences, live events and any other type of National Government Services educational events

Objective

- Assist ACHs with preventing claim rejections by providing
  - A review of three-day payment window policy
  - Instructions for submitting claims that comply with this policy

Agenda

- Three-day payment window policy overview
  - Admitting hospital defined
  - Counting the three days
  - OP diagnostic and nondiagnostic services
  - Policy does not apply to and does not apply when…
- Claim rejections
- Questions and answers
- References

Three-Day Payment Window Policy Overview

Other Names for Three-Day Payment Window

- Preadmission services window
- DRG window
- Payment rule
- Payment window
- 72-hour rule
- 72-hour window
- Three-day rule
- Bundled/bundling
- OP services treated as IP

National Government Services

NGS MU

A Peek Inside the Window

- Being familiar with CMS' long-standing three-day payment window policy can help you
  - Submit claims to Medicare correctly
  - Prevent claim rejections

Did You Know?

- A three-day payment window policy applies to admitting hospitals paid under the IPPS (ACHs)

Three-Day Payment Window Policy General Rule

- When this policy is applicable, admitting ACH
  - Adds certain OP diagnostic services (to be defined) and/or nondiagnostic services (to be defined) rendered to beneficiary onto IP claim when
    - Beneficiary is admitted to ACH as an IP and
    - Admitting ACH (to be defined) rendered such OP services on and/or within three days prior to beneficiary's IP ACH admission date
  - Does not submit such OP services separate from IP claim
    - Deemed to be IP services; paid for within DRG

Three-Day Payment Window Policy General Rule

- This policy is applicable when Medicare Part A can pay for IP ACH claim
  - Medicare Part A can pay for IP ACH claim when
    - Beneficiary is entitled to Part A
    - Beneficiary has IP hospital benefit days under Part A available
    - IP stay is covered by Medicare Part A (medically R&N)

Assumption for This Presentation

- Unless stated otherwise, assume Medicare Part A can pay for IP ACH claim and, thus, the three-day payment window policy applies

Three-Day Payment Window Policy Report OP Services on IP Claim

- To add OP services onto IP claim; report
  - OP services revenue code(s) and charges
  - OP services procedure code(s) and date(s)
  - OP services diagnosis code(s)
  - Admission (admit) date = date beneficiary formally admitted as an IP
  - From date = earliest OP DOS added (See SE1117)
- Could result in a DRG change

Three-Day Payment Window Policy Admitting Hospital

Admitting Hospital – Defined

- Hospital that formally admits beneficiary as an IP
  - Term “admitting hospital” also includes
    - Entity wholly-owned or wholly-operated by admitting hospital or
    - Entity under arrangement with admitting hospital
- When either of above is applicable
  - Add **technical portion** of applicable OP service(s) onto IP claim

Wholly-Owned or Wholly-Operated

- Hospital is sole owner or sole operator
  - Sole owner or sole operator
    - Hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing facility's routine operations), regardless of whether it also has authority to make policies
- Wholly-owned or wholly-operated entities defined in 42 CFR, Section 412.2

Did You Know?

- When determining if the three-day payment window applies, the admitting hospital must consider the OP services it rendered and the OP services rendered by provider-based departments and clinics that it wholly-owns and/or wholly-operates

Admitting Hospital Notifies Part B Entities of IP Admission

- Admitting hospital must make wholly-owned or wholly-operated physician's office or other Part B entity aware of IP admission
  - Physician's office/other Part B entity
    - Appends modifier PD on CMS-1500 claim form or electronic equivalent, to applicable services rendered during payment window
- Refer to
  - CR7502, SE20024 and CMS' FAQs for CR7502

National Government Services

NGS MU

Three-Day Payment Window Policy
Counting the Three Days

Three-Day Payment Window – Day Count

- Three-day timeframe
  - OP services rendered to beneficiary
    - On IP admission date **and**
    - Within three days prior to IP admission date
      - **So, you must consider a total of four days**

Three-Day Payment Window – Day Count

- How to count three-days – Example
  - If IP admission date = 4/15/2021
    - Review all following dates to determine if admitting hospital (or entity that falls under this definition) rendered OP services that it must add onto IP claim
      - 4/15/2021 (IP admission date)
      - 4/14/2021 (one day prior to IP admission date)
      - 4/13/2021 (two days prior to IP admission date)
      - 4/12/2021 (three days prior to IP admission date)

Three-Day Payment Window Policy
OP Diagnostic Services

OP Diagnostic Services – Defined

- For purposes of payment window policy, diagnostic services are defined by presence of certain revenue (and CPT/HCPCS) codes on OP claim
  - CMS maintains a list of **diagnostic revenue codes**
    - See CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 3, Section 40.3
    - **See slides 26 – 28**

OP Diagnostic Services Rendered On and/or Prior to IP Admission Date

- What must admitting ACH do?
  - Add OP diagnostic services onto IP claim when
    - Rendered on IP admission date and/or within three days prior to IP admission date
      - Regardless of relationship to IP admission
        - » Do not submit OP claim for such OP diagnostic services

OP Diagnostic Services Revenue Codes with Descriptions

- 0254 = Pharmacy, drugs incident to other diagnostic services
- 0255 = Pharmacy, drugs incident to radiology
- 030X = Laboratory
- 031X = Laboratory – pathological
- 032X = Radiology – diagnostic
- 0341 = Nuclear medicine – diagnostic procedures
- 0343 = Nuclear medicine – diagnostic radiopharmaceuticals
- 035X = Computed tomographic scan

OP Diagnostic Services Revenue Codes with Descriptions

- 0371 = Anesthesia – incident to radiology
- 0372 = Anesthesia – incident to other diagnostic services
- 040X = Other imaging services
  - Except 0403 = screening mammogram; not billable on TOB 11X
- 046X = Pulmonary function
- 0471 = Audiology – diagnostic
- 0481 = Cardiology – cardiac cath lab
- 0482 = Cardiology – stress test
- 0483 = Cardiology – echo cardiology

OP Diagnostic Services Revenue Codes with Descriptions

- **0489** = Cardiology – other cardiology
  - For **0481 and 0489**, CPT/HCPCS codes = 93451–93464, 93503, 93505, 93530–93533, 93561–93568, 93571–93572, G0275 and G0278
- 053X = Osteopathic services
- 061X = Magnetic Resonance Technology
- 062X = Medical/surgical supplies
- 073X = Electrocardiogram
- 074X = Electroencephalogram
- 0918 = Behavioral health treatment/services testing
- 092X = Other diagnostic services

OP Diagnostic Services – Example

- Situation
  - Beneficiary
    - Receives OP services for revenue code 032X (diagnostic radiology) at ACH on 4/12, 4/13, 4/14, and/or 4/15 of 2021
    - Is then admitted to same ACH on 4/15/2021 as an IP
- Admitting ACH
  - Adds OP services for revenue code 032X onto IP claim
  - Must not submit OP claim for revenue code 032X

Three-Day Payment Window Policy OP Nondiagnostic Services

OP Nondiagnostic Services Defined

- For purposes of payment window policy, nondiagnostic services are defined by presence of certain revenue (and CPT/HCPCS) codes on OP claim
  - CMS does not maintain a list of nondiagnostic revenue codes
  - Such revenue (and CPT/HCPCS) codes that are not on CMS' diagnostic list

OP Nondiagnostic Services Rendered On IP Admission Date

- What must admitting ACH do?
  - Add OP nondiagnostic services onto IP claim when
    - Rendered on IP admission date, regardless of relationship to IP admission
      - Do not submit OP claim for such OP nondiagnostic services

OP Nondiagnostic Services Rendered Prior to IP Admission Date

- What must admitting ACH do?
  - Add OP nondiagnostic services onto IP claim when
    - Rendered within three days prior to IP admission date and
    - Related to IP admission
  - Submit OP nondiagnostic services on TOB 13X when
    - Rendered within three days prior to IP admission date and
    - Not related to IP admission
      - Report CC 51 on claim; indicates OP nondiagnostic services are clinically distinct or independent from reason for IP admission

Reporting CC 51 on OP Nondiagnostic Claim

- CC 51
  - May report only when OP nondiagnostic services are rendered within three days prior to IP admission date
- Notes
  - CC 51 = attestation that such services are clinically distinct or independent from reason for IP admission
  - Claim is subject to review
  - Hospital must have documentation to support CC 51
  - Reporting CC 51 is a clinical, not a billing, decision

Inpatient-Only Procedure Rendered in OP Setting Prior to IP ACH Admission

- Treat same as OP nondiagnostic
- Add service onto IP claim when
  - Rendered on IP admission date regardless of relationship to IP admission and/or
  - Rendered within three days prior to IP admission date and related to IP admission
- Review CR7443 first and then CR9097

OP Nondiagnostic Services – What Not To Do

- Do not submit OP claim for OP nondiagnostic services when
  - Rendered on IP admission date, regardless of relationship to IP admission
  - Rendered within three days prior to IP admission date and related to IP admission

OP Nondiagnostic Services Rendered On IP Admission Date – Example

- Situation
  - Beneficiary
    - Receives OP services for revenue code 045X (ER) at ACH on 4/12/2021 and
    - Is then admitted to same ACH as an IP on 4/12/2021
- Admitting ACH
  - Adds OP services for revenue code 045X onto IP claim
  - Must not submit OP claim for revenue code 045X

OP Nondiagnostic Services Rendered Prior to IP Admission Date – Example

- Situation
  - Beneficiary
    - Receives OP services for revenue code 045X (ER) at ACH on 4/12, 4/13, and/or 4/14 of 2021 and
    - Is then admitted to same ACH as an IP on 4/15/2021
- Admitting ACH
  - Determines if OP services are clinically distinct or independent from reason for IP admission
    - If no, adds such services onto IP claim (must not submit OP claim for revenue code 045X)
    - If yes, submits OP claim for such services with CC 51

Three-Day Payment Window Policy Does Not Apply to…

Ambulance and Maintenance Dialysis Services

- Submit following services separate from IP claim since payment window does not apply
  - Ambulance services (revenue code 0540)
  - Maintenance dialysis services (See CR7142)

OP Nondiagnostic Services Not Payable Under Part B

- Per CR8041, do not add, onto IP claim, any OP nondiagnostic services that are not payable under Part B
  - Example: Oral medications are considered self-administered drugs under Part B, are not payable under OPPS and must not be reported on IP claim
- Exception per CR9097
  - A related IP-only procedure rendered in OP setting within payment window timeframe (discussed on slide 35)

Certain Provider Types

- Following providers are excluded from payment window policy
  - Part A services by SNFs, HHAs, and hospices
  - OP services included in RHC or FQHC all-inclusive rate
  - CAHs unless CAH is wholly-owned or wholly-operated by a non-CAH

OP Services Rendered More Than Three Days Prior to IP ACH Admission Date

- Submit OP services rendered more than three days prior to IP admission separate from IP claim
  - Even when all OP services are rendered during a single, continuous OP encounter
    - Examples of services that may span multiple dates
      - Observation (revenue code 0762) – See slide 44
      - ER encounter (revenue code 0450) – See slide 45
- CMS is aware this results in payable OP and IP claims

Services That Span Multiple Dates – Observation (Revenue Code 0762)

- If observation spans more than one calendar day
  - Determine date observation care began
    - If that date is outside payment window
      - Submit revenue code 0762 on OP claim and bill all hours of entire observation period on single line with LIDOS = date observation began
    - If that date is within payment window
      - Add such service onto IP claim
- Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 4, Section 290.2.2

Services That Span Multiple Dates – ER Encounter (Revenue Code 0450)

- When ER encounter spans more than one calendar day
  - Determine on what date beneficiary entered ER
    - If that date is outside payment window
      - ER encounter – Submit revenue code 0450 on OP claim with LIDOS = date beneficiary entered ER
      - Other ER services – Submit revenue codes on OP claim with LIDOS = DOS
    - If that date is within payment window
      - Add ER encounter onto IP claim
      - Other ER services – Review revenue codes for payment window policy
- Refer to CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 4, Section 180.6

Three-Day Payment Window Policy Does Not Apply When…

Did You Know?

- In CR7672, CMS clarified that in situations where there is no Part A coverage for IP stay, there is no IP service into which OP services must be bundled
  - Therefore, OP services provided to beneficiary prior to IP admission (i.e., IP admission order) may be separately billed to Part B as “the OP services that they were”

Three-Day Payment Window Policy Does Not Apply When

- Medicare Part A cannot pay for IP claim
  - Medicare Part A cannot pay for IP claim when
    - Beneficiary is not entitled to Part A
    - Beneficiary exhausted IP hospital Part A benefit days
    - IP stay is not covered by Medicare (i.e., not medically R&N) per decision made by MAC or Medical Review Contractor
    - IP stay is not covered by Medicare (i.e., not medically R&N) per hospital self-audit

Billing of Payment Window Services When IP Hospital Stay is Not Covered

- If Medicare Part A cannot pay for IP claim because
  - Beneficiary is not entitled to or exhausted Part A benefits
    - Submit
      - TOB 13x and/or 14X for OP payment window services
      - TOB 12X for billable IP services
      - TOB 110 for IP stay if IP hospital benefit days exhausted at admission
  - Refer to CMS IOM Publications
    - 100-02, *Medicare Benefit Policy Manual*, Chapter 6, Section 10.2
    - 100-04, *Medicare Claims Processing Manual*, Chapter 4, Section 240.5

Billing of Payment Window Services When IP ACH Stay is Not Covered

- If Medicare Part A cannot pay for IP claim because beneficiary's IP stay is not covered (i.e., not medically R&N)
  - Per decision by MAC or MRC
    - Submit an appeal of IP denied claim or appropriate claims if Part A to B rebilling criteria is met
    - Refer to CRs 8445 and 8666
  - Per decision made by ACH during a self-audit
    - Follow CRs 8445 and 8666

Three-Day Payment Window Policy Claim Rejections

Three-Day Payment Window Rejection Reason Codes

- Incoming claims reject if not in compliance
  - OP claims
    - With diagnostic services reject with **C7109**
    - With nondiagnostic services reject with **C7114**
      - Bypassed if has CC 51 and DOS does not = admit date
  - IP claims
    - With diagnostic services reject with **C7113**
    - With nondiagnostic services reject with **C7115**
      - Bypassed if has CC 51 and DOS does not = admit date

Resolving OP Claim Rejections C7109 and C7114

- Adjust IP claim
  - TOB XX7
  - CC = D1 and adjustment reason code = OT
  - Add applicable OP services
    - Diagnostic services rendered on and/or within three days prior to IP admission date
    - Nondiagnostic services rendered on IP admission date
    - Nondiagnostic services rendered within three days prior to IP admission date that are related to IP admission

Resolving IP Claim Rejections C7113 and C7115

- Cancel OP claim
  - TOB XX8
  - CC = D6 and adjustment reason code = OT (issue refund)
- Resubmit IP claim
  - Add applicable OP services
    - Diagnostic services rendered on and/or within three days prior to IP admission date
    - Nondiagnostic services rendered on IP admission date
    - Nondiagnostic services rendered within three days prior to IP admission date that are related to IP admission

Preventing Claim Rejections

- Many actions admitting ACHs can take
  - Be familiar with policy guidelines
  - Be aware of which entities wholly-owned/operated
  - Review OP services rendered within payment window timeframe, by each revenue code, to categorize such services as diagnostic or nondiagnostic and then apply appropriate guideline based on type of service(s) and date(s) rendered
  - Understand when can or cannot separately bill for OP services

Re-Cap – Follow These Rules to Prevent Claim Rejections

- Admitting ACHs **may not** separately bill for
  - OP diagnostic services rendered
    - On date of IP admission and/or
    - Within three days prior to date of IP admission
  - OP nondiagnostic services rendered
    - On IP admission date
      - Regardless of relationship to IP admission
    - Within three days prior to IP admission date
      - If such services are clinically associated with reason for IP admission (assumed to be clinically associated unless hospital attests they are not)

Re-Cap – Follow These Rules to Prevent Claim Rejections

- Admitting ACHs **may** separately bill for
  - OP nondiagnostic services rendered
    - Within three days prior to date of IP admission
      - If such services are clinically distinct or independent from reason for IP admission (hospital attests to this by reporting CC 51 on OP claim)
  - Notes
    - ACH has documentation to support CC 51
    - Claim may be subject to subsequent review
    - Claim must meet all applicable filing deadlines

What You Should Do Now

- Review references slides
- Be familiar with three-day payment window
- Establish procedures to comply with policies and submit claims accurately
- Share today's presentation with other staff members
- Attend future education

National Government Services

NGS MU

Three-Day Payment Window Policy References

Education Tab

- For a complete listing of our educational activities, visit the Education tab on our website
  - Webinars, Teleconferences & Events (including Past Events)
  - Medicare University
  - New Provider Center
  - Job Aids & Manuals
  - POE Advisory Group and much more
- Easiest, fastest way to be aware of all POE information

National Government Services Reference

- Website article
  - Medicare Paid Hospital Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient IPPS Hospital Stays

CMS References

- Code of Federal Regulations: 42 CFR 412.2(c) (5) and 413.40 (c) (2)
- Acute Inpatient PPS
  - Memorandum: Implementation of New Statutory Provision Pertaining to Medicare 3-Day Payment Window
  - FAQs for CR 7502: Medicare's 3-Day Payment Window and the Impacts on Wholly Owned or Wholly Operated Physician Practices
- MLN Booklet® *Acute Care Hospital Inpatient Prospective Payment System*
- CMS-1599-F

CMS References – IOMs

- CMS Internet-Only Manuals (IOMs)
  - Publication 100-02, *Medicare Benefit Policy Manual*
    - Chapter 6, Sections
      - 10.1 “Reasonable and Necessary Part A Hospital Inpatient Claim Denials”
      - 10.2 “Other Circumstances in Which Payment Cannot Be Made Under Part A
      - 10.3 “Hospital Inpatient Services Paid Only Under Part B”
  - Publication 100-04, *Medicare Claims Processing Manual*
    - Chapter 3, Section
      - 40.3 “OP Services Treated as IP Services”

CMS References – IOMs

- Chapter 4, Sections
  - 10.12 “Payment Window for OP Services Treated as IP Services”
  - 180.6 “Emergency Room Services That Span Multiple Service Dates”
  - 180.7 “Inpatient-Only Services”
  - 240.5 “Payment of Part B Services in Payment Window for OP Services Treated as IP Services When Payment Cannot Be Made Under Part A
  - 290.2.2 “Reporting Hours of Observation”
- Chapter 12, Sections
  - 90.7 “Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (Physician Practices and Clinics): 3-Day Payment Window
  - 90.7.1 “Payment Methodology 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (Physician Practices and Clinics)”

CMS References – Transmittals

- CMS Transmittals
  - Search for CRs by number
    - 7142 – Clarification of Payment Window for OP Services Treated as IP Services
    - 7443 – July 2011 Update of the Hospital OPPS (#7)
    - 7502 Revised – Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly-Owned or Wholly-Operated Physician Practices
    - 7672 Revised – January 2012 Update of the Hospital OPPS
    - 8041 Revised – FY 2013 IPPS & LTCH Changes

CMS References – Transmittals

- 8046 – Modification of Payment Window Edit in the CWF to Modify Diagnostic Service List
- 8185 – CMS Administrator's Ruling: Part A to Part B Rebilling of Denied Hospital IP Claims
- 8445 Revised – Implementing Part B IP Payment Policies from CMS-1599-F
- 8666 – Implementing Part B IP Payment Policies from CMS-1599-F
- 9097 Revised – April 2015 Update of Hospital OPPS
- 11312 – Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication
- 11559 – Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent With Current Policy

CMS References - MLN Matters® Articles

- MLN Matters® Articles
  - MM7142 Revised
  - MM7443
  - MM7502 Revised
  - MM7572 Revised
  - MM8041 Revised
  - MM8046
  - MM8185
  - MM8445 Revised
  - MM8666
  - MM9097
  - MM11312
  - MM11559

CMS References

- MLN Matters® Special Edition Articles
  - *SE1117: Correct Provider Billing of Admission Date and Statement Covers Period*
    - NUBC definitions for “admission date” and “statement covers period” for claims submitted on/after 10/1/2011 with discharge dates on/after 7/1/2011
  - *SE1232: Frequently Asked Questions (FAQs) on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients*
  - *SE20024: FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients*

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

Follow us

National Government Services

NGS MU