NGS Medicare Virtual Conference

Fall 2021

Acute Care Hospitals: Outpatient Services Provided Shortly Before/During an Inpatient Stay

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Today’s Presenters

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Objective

- Assist ACHs with preventing claim rejections for various IP versus OP claim overlap policies
  - Three-day payment window policy
  - Under arrangement policy
  - LOA policy
  - IPF, IRF and LTCH interrupted stay policies

Agenda

- Three-day payment window policy overview
- Under arrangement policy
- LOAs
- Interrupted stays
- References – See handout
- Questions and answers

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

Three-Day Payment Window Policy General Rule

- When policy is applicable, admitting ACH
  - Adds certain OP diagnostic services and/or nondiagnostic services rendered to beneficiary to IP claim when
    - Beneficiary is admitted to ACH as IP and
    - Admitting ACH 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
    - Such OP services are deemed to be IP services
    - Considered paid for within DRG

Three-Day Payment Window Policy General Rule

- Policy is applicable when Medicare Part A can pay for IP ACH claim
  - 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
    - Beneficiary's IP stay is covered by Part A (medically R&N)
- Assumption for this presentation
  - Assume Part A can pay for IP ACH claim and three-day payment window policy applies

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

- To add OP services to IP claim; report
  - OP services revenue codes and charges
  - OP services procedure codes and date(s)
  - OP services diagnosis codes
  - Admission date = date beneficiary formally admitted as IP
  - From date = earliest OP DOS added
- Could result in DRG change

Admitting Hospital – Defined

- Hospital that formally admits beneficiary as IP
  - Term "admitting hospital" also includes
    - Entities wholly-owned or wholly-operated by admitting hospital or
    - Entities under arrangement with admitting hospital
- When either of above is applicable
  - Add technical portion of applicable OP services to IP claim

Wholly-Owned or Wholly-Operated

- Hospital is 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

Admitting Hospital's Responsibilities

- Admitting hospital must
  - Consider OP services rendered by provider-based departments and clinics that it wholly-owns and/or wholly-operates when determining if payment window applies
  - 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 837P) to applicable services rendered during payment window

Three-Day Payment Window – Day Count

- Three-day policy but four days to consider
  - OP services rendered on IP admission date and within three days prior to IP admission date
- How to count days – Example
  - If IP admission date is 4/15/2021, review for OP services
    - – 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)

OP Diagnostic Services – Defined

- Defined by presence of certain revenue (and CPT/HCPCS) codes on OP claim
  - Diagnostic revenue code list in CMS IOM Publication 100-04, *Medicare Claims Processing Manual,* Chapter 3, Section 40.3
    - 0254, 0255, 030X, 031X, 032X, 0341, 0343, 035X, 0371, 0372, 040X, 046X, 0471, 0481, 0482, 0483, 0489, 053X, 061X, 062X, 073X, 074X, 0918 and 092X
      - Except 0403 screening mammogram not billable on 11X
      - For 0481 and 0489, CPT/HCPCs codes = 93451-93464, 93503, 93505, 93530-93533, 93561-93568, 93571-93572, G0275 and G0278

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

- Admitting ACH must add OP diagnostic services to IP claim when
  - Rendered on and/or within three days prior to IP admission date
    - Regardless of relationship to IP admission
- Example
  - Beneficiary receives OP service for revenue code 032X at ACH on 4/12, 4/13, 4/14, and/or 4/15 of 2021; is admitted as IP to same ACH on 4/15/2021
  - ACH adds OP service for revenue code 032X to IP claim

OP Nondiagnostic Services Defined

- Defined by presence of certain revenue (and CPT/HCPCS) codes on OP claim
  - No list but considered to be revenue (and CPT/HCPCS) codes not on CMS' diagnostic revenue code list

OP Nondiagnostic Services Rendered On IP Admission Date

- Admitting ACH must add OP nondiagnostic services to IP claim when
  - Rendered on IP admission date
    - Regardless of relationship to IP admission
- Example
  - Beneficiary receives OP service for revenue code 045X at ACH on 4/12/2021; is admitted as IP to same ACH on 4/12/2021
  - ACH adds OP service for revenue code 045X to IP claim

OP Nondiagnostic Services Rendered Prior to IP Admission Date and CC 51

- Admitting ACH must
  - Add OP nondiagnostic services to 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
        - » Add CC 51 = attestation that services are clinically distinct or independent from reason for IP admission (clinical decision)
        - » Claim subject to review; must have documentation to support CC 51

OP Nondiagnostic Services Rendered Prior to IP Admission Date – Example

- Example
  - Beneficiary receives OP service for revenue code 045X at ACH on 4/12, 4/13 and/or 4/14 of 2021; is admitted to same ACH as IP on 4/15/2021
  - Admitting ACH determines if OP service is clinically distinct or independent from reason for IP admission
    - If no, adds services to IP claim
    - If yes, submits OP claim for such service with CC 51

Policy Does Not Apply to

- Certain OP services
  - Ambulance services (revenue code 0540)
  - Maintenance dialysis services (CR7142)
  - OP nondiagnostic services not payable under Part B
    - Per CR8041, e.g., oral medications (self-administered drugs)
    - Per CR9097, exception is **IP-only procedure rendered in OP setting** which can be added to IP claim when
      - Rendered on IP admission date, regardless of relationship to IP admission and/or within three days prior to IP admission date and is related to IP admission (review CR7443 and then CR9097)

Policy Does Not Apply to

- Certain provider types
  - Part A services by SNFs, HHAs, and hospices
  - OP services in RHC or FQHC all-inclusive rate
  - CAHs unless is wholly-owned or wholly-operated by non-CAH
- OP services rendered more than three days prior to IP admission date
  - Even when rendered during a single, continuous OP encounter and **span multiple dates**

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

- If observation spans more than a 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 observation revenue code 0762 to IP claim

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

- If ER encounter spans more than a calendar day
  - Determine 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
    - If that date is within payment window
      - Add ER encounter revenue code 0450 to IP claim

Three-Day Payment Window Policy Does Not Apply When…

- Medicare Part A cannot pay for IP claim
  - Part A cannot pay for IP claim when
    - Beneficiary is not entitled to Part A
    - Beneficiary exhausted IP hospital 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 ACH Stay Is Not Covered

- If 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 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
      - May submit appeal of IP denied claim or appropriate claims if Part A to B rebilling criteria is met
      - See CRs 8445 and 8666
    - Per decision made by ACH during self-audit
      - See CRs 8445 and 8666

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 Claim Rejections

- OP claim rejections C7109 and C7114
  - Adjust IP claim (TOB XX7) and add applicable OP services
    - Use CC = D1 and adjustment reason code = OT
- IP claim rejections C7113 and C7115
  - Cancel OP claim (TOB XX8)
    - Use CC = D6 and adjustment reason code = OT (issue refund)
  - Resubmit IP claim with applicable OP services

Recap – Follow These Rules to Prevent Claim Rejections

- Admitting ACHs **may not** separately bill for
  - OP diagnostic services rendered
    - On and/or within three days prior to IP admission date, regardless of relationship to 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 unless hospital attests they are not)
- Admitting ACHs **may** separately bill for
  - OP nondiagnostic services rendered
    - Within three days prior to IP admission date if such services are clinically distinct or independent from reason for IP admission (hospital attest to this by reporting CC 51 on claim)

Tips for Compliance with Three-Day Payment Window Policy

- Be familiar with policy guidelines
- Know which entities ACH wholly-owns or operates
- Review OP services rendered within payment window by revenue code
  - Determine if diagnostic or nondiagnostic, apply guideline based on types and dates of service
- Communicate between IP and OP departments
- Understand when you may or may not separately bill for OP services within payment window

Billing Services Rendered Under Arrangement

Services Furnished to Your Inpatients

- All items and nonphysician services furnished to hospital inpatients must be
  - Furnished directly by hospital or
  - Billed through hospital **under arrangement**
- Such services covered under Part A by PPS rate
  - Includes transportation by ambulance to and from another hospital or freestanding facility to receive specialized services (diagnostic or nondiagnostic) not available at hospital where beneficiary is an inpatient

Under Arrangement Policy – Defined

- What is meant by under arrangement?
  - ACH that admitted beneficiary as IP
    - May not be able to provide certain ancillary services during stay
    - Arranges for beneficiary to receive such services at another facility
      - Typically done as OP and beneficiary returns to ACH by midnight on same day
    - Pays other facility for such services and any transportation
    - Reports its costs on its IP claim

Under Arrangement Policy – Billing

- Reporting arranged services and costs on IP claim
  - ACH that admitted beneficiary as IP
    - Reports
      - Revenue code for ancillary service provided by other facility and
      - All associated costs including transportation costs
      - Costs = amount you paid other facility/entities
    - Does not report
      - Revenue code for transportation (0540)

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Under Arrangement – Billing Example

- Beneficiary
  - Admitted as IP to hospital A and needs MRI (revenue code 0612) only hospital B can provide
- Hospital A
  - Arranges for beneficiary to receive MRI at hospital B as OP and transportation to/from each hospital
  - Submits IP claim and reports revenue code 0612 with cost of MRI and transportation (total paid to hospital B and transportation provider)

Under Arrangement – Billing Example

- Hospital B
  - Charges hospital A for MRI done as OP
- Transportation provider
  - Charges hospital A for transportation provided

ACH Provides OP Services to Inpatients of Other Hospitals

- Since **under arrangement policy** applies to all hospitals
  - If your ACH renders OP services to beneficiary who is in a covered Part A stay at another hospital (CAH, IPF, IRF or LTCH)
    - Submit your OP services to that hospital who must pay **under arrangement**
      - Do not submit claim to Medicare

LOAs

LOA

- Should take place when beneficiary
  - Leaves ACH
  - Is expected to return to same ACH for related care and
  - Does not require hospital level of care in interim
- LOA is
  - Time period between when beneficiary leaves and returns to ACH

LOA Situations

- Include but are not limited to
  - Surgery could not be scheduled immediately
  - Specific surgical team is not available
  - Bilateral surgery was planned
  - Further treatment is needed after tests but cannot begin immediately

LOA – Claim Instructions

- Submit one claim from beneficiary's original admission through final discharge
  - Report LOA days as follows
    - OSC 74
      - From date = date beneficiary is placed on LOA
      - Through date = last date beneficiary is not in ACH at midnight
    - Noncovered days
    - Revenue code 0180 and number of units

LOA – When Beneficiary Does Not Return

- If your ACH places beneficiary on LOA but he/she does not return
  - Communicate with beneficiary/representative to determine status
  - May submit discharge claim with through date = date LOA began
    - CMS has not set certain amount of time that must pass before ACH can submit discharge claim

LOA – Payment and Services Rendered During LOAs

- When LOA occurs, Medicare
  - Pays one DRG for both stays (billed as one claim)
  - Will not pay separately for any OP hospital/facility services rendered during LOA
    - If your ACH rendered OP services to beneficiary during LOA from your ACH
      – Report services on IP ACH claim; do not bill Medicare
    - If your ACH rendered OP services to beneficiary during LOA from another ACH
      – Bill that ACH **under arrangement**

Interruptions in IPF, IRF and LTCH Inpatient Stays

Did You Know

- There are interrupted stay policies that apply to IPFs, IRFs and LTCHs under which Medicare will not pay ACHs for certain services you provide to beneficiaries who are on interruptions from IP stays in such facilities

Three-Day or Less Interruption From IPF

- If ACH renders OP or IP services to beneficiary who is on interruption from IPF
  - Submit services as follows
    - Beneficiary is on **one-day interruption** from IPF, submit your services to IPF to be paid **under arrangement**
      - **One-day** = beneficiary leaves IPF; returns by midnight same day
    - Beneficiary is **on two-or three-day interruption** from IPF, submit your services to Medicare
      - **Two-day** = beneficiary leaves IPF; returns by midnight of next day
      - **Three-day** = beneficiary leaves IPF; returns by midnight of second following day

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Three-Day or Less Interruption From IRF

- If ACH renders OP or IP services to beneficiary who is on interruption from IRF
  - Submit services as follows
    - Beneficiary is on **one-day interruption** from IRF, submit your services to IRF to be paid **under arrangement**
      - **One-day** = beneficiary leaves IRF; returns by midnight same day
    - Beneficiary is **on two-or three-day interruption** from IRF, submit your services to Medicare
      - **Two-day** = beneficiary leaves IRF; returns by midnight of next day
      - **Three-day** = beneficiary leaves IRF; returns by midnight of second following day

Three-Day or Less Interruption From LTCH

- If ACH renders OP or IP services to beneficiary who is on interruption from LTCH
  - Submit services as follows
    - Beneficiary is on **one-, two-or three-day interruption** from LTCH, submit your services to LTCH to be paid **under arrangement**
      - He/she leaves LTCH and returns to same LTCH
        - » **One-day** = beneficiary leaves and returns by midnight of same day
        - » **Two-day** = beneficiary leaves and returns by midnight of next day
        - » **Three-day** = beneficiary leaves and returns by midnight of second following day

Greater Than Three-Day Interruption From LTCH

- If ACH renders OP or IP services to beneficiary who is on interruption from LTCH
  - Submit your services as follows
    - Beneficiary is on **four-to nine-day interruption** from LTCH, submit your services to Medicare
      - Beneficiary is transferred/discharged from (leaves) LTCH, is admitted directly to ACH, and is readmitted to LTCH within 4–9 days
      - "Greater than three-day" interrupted stay policy governs beginning on day four
      - Day of discharge/transfer from LTCH and following two days are governed by "three-day or less" interrupted stay policy

Tips for Compliance With Under Arrangement Policy

- Be familiar with policy guidelines
- Communicate with beneficiary and facilities
- Understand when you can separately bill Medicare and when you must bill another facility for services
- Cooperate with other facilities that ask you to cancel your Medicare claim and to bill them under arrangement

What You Should Do Now

- Review **references handout**
- Be familiar with policies intended to prevent submission of duplicate or overlapping claims
- Establish procedures to comply with policies and submit claims accurately
- Share today's presentation with staff members
- Attend future education

Thank You!

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

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