

 HAWAII HEALTH SYSTEMS C O R P O R A T I O N <i>"Touching Lives Everyday"</i> Policies and Procedures	<i>Quality Through Compliance</i>	Policy No.: FIN 0514
		Revision No.: N/A
Subject: <i>Outpatient Services and Medicare Three Day Window (72 Hour Rule)</i>	Issued by: Corporate Compliance Committee	Effective Date: September 15, 2000
	Approved by: Thomas M. Driskill, Jr. President & CEO	Supersedes Policy: N/A Page: 1 of 7

I. PURPOSE: To ensure Medicare outpatient services provided prior to an inpatient admission are billed in accordance with HCFA regulations.

II. POLICY: Medicare outpatient services will be processed as follows:

A. Outpatient services will be combined with the inpatient admission when:

1. The services are provided by the admitting facility, or an entity "wholly owned or operated" (see definition on page 7) by the admitting facility AND
2. The services are outpatient diagnostic and/or non-diagnostic/therapeutic services which meet the following criteria:
 - a. For Prospective Payment System (PPS) Facilities: i) outpatient diagnostic services provided within three (3) days of the admission, or ii) non-diagnostic or therapeutic outpatient services provided within three (3) days of the admission and "related" to the inpatient admission. Related services are defined as those in which the diagnosis of the outpatient visit and the principal diagnosis of the inpatient admission are an exact match to the fifth digit level of the ICD-9-CM diagnosis codes. Although the regulations state exact match, fiscal intermediaries may edit claims using a different interpretation. If your intermediary requires that claims be combined with less than a fifth digit level match of the diagnosis codes, the claims may be combined in accordance with the intermediary interpretation.
 - b. For Non-Prospective Payment System (Non-PPS) Facilities/Units: i) outpatient diagnostic services provided within one (1) day of the admission, or ii) non-diagnostic or therapeutic outpatient services provided within one (1) day of the admission and "related" to the inpatient admission. Related services are defined as those in which the principal diagnosis of the outpatient visit and the principal diagnosis of the inpatient admission are an exact match to the fifth digit level of the ICD-9-CM diagnosis codes. Although the regulations state exact match, fiscal intermediaries may edit claims using a different interpretation. If your intermediary requires that claims be combined with less than a fifth digit level

match of the diagnosis codes, the claims may be combined in accordance with the intermediary interpretation.

- c. The beneficiary must have Part A coverage. If the patient has Part B only, this policy does not apply.

B. The following exceptions apply to this policy:

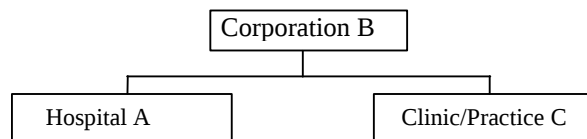
1. Services provided by home health agencies, skilled nursing facilities, and hospices prior to an inpatient admission will not be combined with the inpatient bill unless diagnostic services provided by these facilities are payable under Part B. If diagnostic services are payable under Part B, the services would then be subject to the “window.”
2. Ambulance services will be processed as follows:
 - a. Ambulance services related to initial delivery of the patient to the hospital will not be billed with the inpatient admission.
 - b. Ambulance services during the admission (e.g., to take a patient to another facility for an MRI) will be combined with the inpatient admission by the admitting facility only. Hospitals must include the cost of these services in the appropriate ancillary service cost center, *i.e.*, in the cost of the diagnostic or therapeutic service. They are not shown separately under revenue code 540 (Ambulance Services) but rather with the revenue code which is associated with the test(s) performed at the other facility.
3. Professional services personally furnished by physicians will not be combined with the inpatient admission.
4. Under no circumstances will outpatient services be provided in order to:
 - a. “Deliberately” avoid combining outpatient services with inpatient admissions at another facility as outlined in this policy.
 - b. “Deliberately” avoid combining the outpatient services with inpatient admissions by purposefully scheduling services for such reason prior to the applicable “window” as outlined in this policy.

III. PROCEDURE: The following steps must be performed to ensure outpatient services are billed with inpatient claims in accordance with HCFA regulations. The provisions listed apply to the admitting facility, or to an entity “wholly owned or operated” by the hospital (or by another entity under arrangements with the hospital). Facilities that are not “wholly owned or operated” or under arrangements with the admitting hospital are excluded from this procedure as long as there are no deliberate attempts to avoid combining outpatient services with inpatient admissions. It is the responsibility of the Chief Financial Officer at each facility to ensure adherence to this procedure.

A. Implementation:

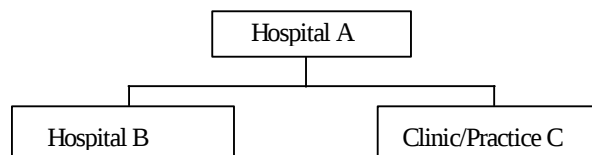
1. Determine all entities which are “wholly owned or operated” by the hospital (or by another entity under arrangements with the hospital) by examining the legal structure of business relationships. Contact Corporate Counsel to determine which legal structure is applicable to ensure outpatient services are properly billed with inpatient claims. A comprehensive list of all “wholly owned or operated” entities must be provided to Registration and the Business Office. This list must be updated as necessary. The following includes examples of legal structures to which the 1 or 3 day window would and would not apply:

EXAMPLE 1:



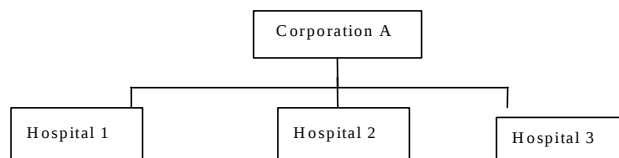
Hospital A is owned by corporation B. Clinic/practice C is also owned by corporation B. Since hospital A does not own or operate clinic/practice C, outpatient services provided at clinic/practice C would not be combined with inpatient admissions at hospital A.

EXAMPLE 2:



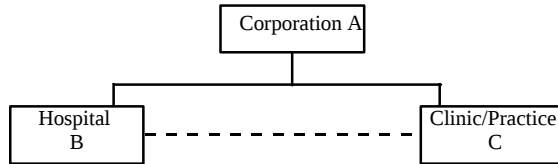
Hospital A is the sole owner of a separate corporation, hospital B. Hospital A is also the sole owner of another separate corporation, clinic/practice C. Outpatient services provided within the applicable “window” at either hospital B or clinic/practice C would need to be combined if the patient were subsequently admitted at hospital A.

EXAMPLE 3:



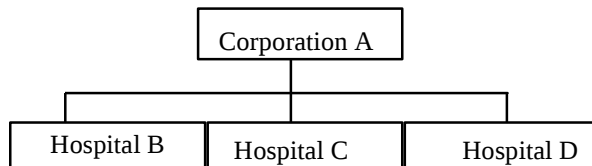
Corporation A owns and operates three (3) hospitals. The three hospitals are not separately incorporated, but each have separate provider numbers. None of the three hospitals operate any of the others. Outpatient services provided at any of the 3 facilities would not be combined if the patient were subsequently admitted at one of the other facilities.

EXAMPLE 4:



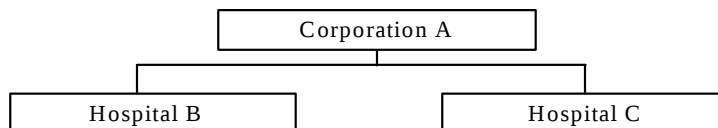
Corporation A is the sole owner of a separate corporation, hospital B. Corporation A is also the sole owner of a separate corporation, clinic/practice C. The management team of hospital B is responsible for the day-to-day affairs of the clinic/practice C. Outpatient services provided within the applicable “window” at clinic/practice C when the patient is subsequently admitted at hospital B, would need to be combined with the inpatient admission.

EXAMPLE 5:



Corporation A owns and operates three hospitals in one city. At one time, the three hospitals were separate corporations with their own provider numbers, but the three hospitals have now been merged into one corporation (corporation A) and have one provider number and the same management team. Outpatient services provided within the applicable “window” at any of the three hospitals must be combined with the inpatient admission when the patient is subsequently admitted at any of the three hospitals.

EXAMPLE 6:



Corporation A owns and operates two (2) hospitals. The two hospitals are not separately incorporated, but each have separate provider numbers. Neither of the hospitals operates the other. Ordinarily, outpatient services provided at either of the 2 facilities would not be combined if the patient were subsequently admitted at the other facility. **However**, Hospital B must not deliberately direct outpatient services to Hospital C if the patient is scheduled to be an inpatient at Hospital B (or vice versa), either before or during the applicable “window”, in order to avoid combining related outpatient and inpatient visits.

2. Determine which facilities fall under the PPS or Non-PPS payment system to ensure outpatient services are properly combined with inpatient claims within the applicable (i.e., 3 or 1 day) window.
3. Establish/develop a Medicare Three/One Day Window Report(s), such as the 72 Hour Report on the Patient Accounting System, that captures all outpatient services by financial class within the “window” prior to an inpatient (Part A) admission. Include reporting for “wholly owned or operated” entities which may not utilize the hospital main A/R system for billing such as physician practices/clinics as determined in Step 1.
4. Business office personnel must work with their electronic processing vendor to establish edits which identify:
 - a. Services that fall within the “window” provided at the same facility; and
 - b. Services provided by other entities which are “wholly owned or operated” and which utilize the same billing vendor.
5. Annual education must be provided on the contents of this policy to all billing staff, clerical employees, managers, supervisors, and personnel involved in preparing and submitting Medicare bills relating to outpatient services rendered in connection with inpatient admissions. The training program shall address the submission of accurate bills for services rendered to Medicare patients, responsibilities of each individual involved in the billing process, the legal sanctions for improper billings and an identification of examples of mis-billing and improper billing to Medicare.
6. Business office personnel must identify intermediary interpretations which vary from the interpretations in this policy. Specific intermediary documentation related to the variance(s) must be obtained and faxed to the Regional Compliance Officer who will work with the Corporate Compliance officer.
7. Compliance with this policy in no way eliminates the facility’s obligation to fully comply with the terms of any settlement agreement entered into between the facility and the federal and/or state government(s). Any questions should be referred to Corporate Legal counsel.

B. Daily:

1. During the process of admitting a patient with Medicare Part A benefits, registration personnel must inquire if the patient has received outpatient services within the applicable “window.” Additionally, review the Medicare Three/One Day Window Report(s) and reporting for “wholly owned or operated” entities which may not utilize the hospital main A/R system for billing physician practice/clinic services.
2. If outpatient services which meet the criteria as defined in the Policy section above are noted registration personnel must perform the following:
 - a. Combine the outpatient services to the inpatient claim. If such services are noted on recurring patient types and the diagnoses are not related to the admission, registration personnel must enter Occurrence Span Code 72 and the overlapping

“from - through” dates of service for the outpatient recurring account into the appropriate field of the inpatient account. However, if the recurring patient services are related to the admission, then services provided within the applicable “window” must be combined to the inpatient bill. Registration personnel must consult with Case Management or Utilization Review Management as deemed appropriate to determine if the diagnoses are related.

- b. If such services are noted which were provided by a “wholly owned or operated” physician practice/clinic, the provider of service must be contacted and instructed to bill the technical components of the services to the admitting facility and write such services off their accounts receivable.

(Note: This responsibility may be assigned to admitting, billing, or other departments as deemed appropriate.)

3. Business office personnel must review on a daily basis the Three-Day Window Report to determine if the patient has received outpatient services within the applicable “window.” Also, review the report for “wholly owned or operated” entities which may not utilize the hospital main A/R system for billing (physician practices/clinics). All occurrences of outpatient services provided within the “window” of inpatient admissions which meet the criteria as defined in the Policy section above should be combined with the inpatient claim.
4. Business office personnel must review electronic processing vendor reports and ensure claims are appropriately combined in accordance with this policy.
5. If an inpatient claim with Medicare Part A benefits is denied or rejected due to overlapping outpatient services, and it is determined that the services were submitted in error, the business office personnel must perform the following steps:
 - a. Perform a “void/cancel of prior claim” routine once the outpatient claim has been paid.

(Note: Refer to the UB92 Manual, for instructions on performing a Void/Cancel of Prior Claim.)
 - b. Combine the related charges from the outpatient claim to the inpatient claim.
 - c. Rebill inpatient claim once Medicare has taken back the outpatient void/cancel claim.
6. If an inpatient claim with Medicare Part A benefits is denied or rejected due to overlapping outpatient non -diagnostic services, and it is determined that services were not related, business office personnel must resubmit the inpatient claim with the appropriate documentation to allow Medicare to adjudicate for payment.

C. Definitions:

1. **Window:** Three days prior to an inpatient admission for PPS facilities/units and one day prior to inpatient admission for Non-PPS facilities/units.
2. **PPS:** Prospective Payment System (Diagnosis Related Groups or DRG reimbursed).
3. **Non-PPS:** Non - Prospective Payment System (not reimbursed by Diagnosis Related Groups).
4. **Diagnostic Services:** Services such as laboratory or radiology to determine if a particular disease process, injury, or illness exist. For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or HCPCS codes:

254 – Drugs incident to other diagnostic services; 255 - Drugs incident to radiology; 30X - Laboratory; 31X – Laboratory pathological; 32X – Radiology diagnostic; 341 - Nuclear medicine, diagnostic; 35X - CT scan; 40X – Other imaging services; 46X – Pulmonary function; 48X - Cardiology, with HCPCS codes 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544-93552, 93561, or 93562; 53X – Osteopathic services; 61X - MRI; 62X - Medical/surgical supplies, incident to radiology or other diagnostic services; 73X – EKG/ECG; 74X - EEG; 92X - Other diagnostic services

5. **Non-Diagnostic Services:** Services such as therapies or treatments which aid in the treatment of a particular disease process, injury, or illness.
6. **Wholly Owned or Operated:** Any entity for which the hospital itself is the sole **owner**; for purposes of consistency, we are also including in this term any entity for which the hospital is the sole **operator**. The hospital need not exercise administrative control over a facility in order to operate it. An operator implements facility policies, but does not necessarily make the policies; operating a facility simply involves conducting the facility's day-to-day activities, as opposed to "control," which involves the power to direct the facility's operations toward specific objectives.