	-		Policy No.:
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Medical Records:			N/A
72-Hour Window Rule			Page:
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- I. **PURPOSE:** To process and code medical records for outpatient services and for inpatient services falling within the HCFA regulations for the three-day window according to standards as outlined in this policy. Specific guidelines on billing procedures are documented in HHSC Policy No. FIN 0514, Outpatient Services and Medicare Three-Day Window (72-Hour Rule).
- **II. POLICY:** Outpatient medical records must not be combined with inpatient admission medical records when claims are combined for billing purposes under HCFA regulations for the three-day window. Coded data will be combined for purposes of claim submission only. For situations in which there is an immediate transfer from outpatient status to inpatient status, outpatient medical records must be combined with inpatient admission medical records. The entire medical record must be coded as an inpatient admission.

## **III. DEFINITIONS:**

- A. <u>Window</u>: Three (3) calendar days prior to an inpatient admission for Prospective Payment System (DRG reimbursed) facilities/units and one day prior to an inpatient admission for Non-PPS facilities/units.
- B. <u>Non-Diagnostic Services</u>: Services such as therapies or treatments which aid in the treatment of a particular disease process, injury or illness.
- C. <u>Related Services</u>: Non-diagnostic or therapeutic outpatient services that are furnished in connection with the principal diagnosis that required the patient to be admitted as an inpatient. In order for the services to meet the definition of related, there must be an exact match to the fifth digit level of ICD-9-CM of the diagnosis for the outpatient service and the principal diagnosis of the inpatient admission. 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. Fiscal intermediary interpretations that vary from the exact match definition should be reported to the Director of Reimbursement.

- **IV. PROCEDURE**: In addition to the steps listed in HHSC Policy No. FIN 0514, Outpatient Services and Medicare Three-Day Window (72-Hour Rule), the following must be performed in order to process Medicare medical records in accordance with accepted standards:
  - A. If outpatient services are rendered and the patient is immediately transferred to an inpatient status, the registration personnel must use a single account number for use with the inpatient and outpatient claim as this is considered to be one encounter.
    - 1. The entire encounter, including any outpatient procedures, must be coded in accordance with HHSC Policy No. PAT 1003, Medical Records: Coding and Documentation for Inpatient Services.
    - 2. The entire encounter must be abstracted under the single account number.
    - 3. All documentation for the visit must be filed in one medical record admission.
    - 4. Patient type should reflect inpatient status.
    - 5. Guidelines should be developed at the hospital to ensure consistency in determining which single account number to use.
  - B. If outpatient services are rendered and the patient goes home, the registration personnel would use one account number for the encounter.
    - 1. This encounter must be coded in accordance with HHSC Policy No. PAT 1002, Medical Records: Coding and Documentation for Outpatient Services.
    - 2. The encounter must be abstracted under the outpatient account number.
    - 3. The outpatient record must be filed per the facility's outpatient record filing policy and procedure.
  - C. If a Medicare inpatient admission occurs within three days of an outpatient service provided at the same hospital (see HHSC Policy No. FIN 0514, Outpatient Services and Medicare Three-Day Window (72-Hour Rule), the inpatient admission must receive a new account number.
    - 1. The outpatient encounter must be:
      - a. Coded following HHSC Policy No. PAT 1002, Medical Records: Coding and Documentation for Outpatient Services;
      - b. Abstracted under the outpatient account number; and
      - c. Filed per the facility's outpatient record filing policy and procedure.
    - 2. The inpatient admission must be:
      - a. Coded following HHSC Policy No. PAT 1003, Medical Records: Coding and Documentation for Inpatient Services;
      - b. Abstracted under the inpatient account number; and
      - c. Filed per the facility's inpatient record filing policy and procedure.

- 3. The Business Office shall notify the Medical Records Department Director, designee, or the Utilization Review Coordinator of accounts that fall into the Medicare Three-Day Window. The Medical Records Department Director, designee, or the Utilization Review Coordinator must review the inpatient and outpatient records in order to accomplish the following:
  - a. For any diagnostic outpatient service, provide Business Office staff with sequence of the combined outpatient and inpatient ICD-9-CM diagnosis and procedure code(s) following HHSC Policy No. PAT 1003, Medical Records: Coding and Documentation for Inpatient Services. Calculate the DRG based on any coding changes and provide this information to the Business Office staff.
  - b. For non-diagnostic or therapeutic outpatient services, the Medical Records Department Director, designee or Utilization Review Coordinator determines if the services are related and if not, notify Business Office that the claims do not have to be combined. 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 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. Fiscal intermediary interpretations that vary from the exact match definition should be reported to the Collections Supervisor and Medical Records Department Director.
  - c. If the non-diagnostic or therapeutic outpatient service is determined to be related to the inpatient admission and the claims must be combined, sequence the diagnosis and any procedure codes according to HHSC Policy No. PAT 1003, Medical Records: Coding and Documentation for Inpatient Services. Information is forwarded to the Business Office staff for use in submitting the claim.
- 4. The Medical Records Department personnel will notify the Business Office inpatient billing clerk:
  - a. If the inpatient and outpatient account have to be combined, the Business Office shall submit one claim for all services.
  - b. If the inpatient and outpatient accounts do not have to be combined, the Business Office shall submit two separate claims, one for the inpatient admission and the second for the outpatient services provided.
- D. If an inpatient admission occurs within three days of an outpatient service performed in another hospital that is wholly owned or operated by the admitting hospital (see HHSC Policy No. FIN 0514, Outpatient Services and Medicare Three-Day Window (72-Hour Rule), the inpatient admission medical record is processed independently of the outpatient record from the hospital providing the outpatient services.
  - 1. The inpatient admission must be:

- a. Coded at the admitting hospital following HHSC Policy No. PAT 1003, Medical Records: Coding and Documentation for Inpatient Services;
- b. Abstracted at the admitting hospital under the inpatient account number; and
- c. Filed at the admitting hospital per the facility's inpatient record filing policy and procedure.
- 2. The outpatient encounter from the facility providing the outpatient services must be:
  - a. Coded at the hospital providing the outpatient service following HHSC Policy No. PAT 1002, Medical Records: Coding and Documentation for Outpatient Services;
  - b. Abstracted at the hospital providing the outpatient service; and
  - c. Filed at the hospital providing the outpatient service.
- 3. When the Business Office and/or Admitting/Registration personnel obtains or receives information that the patient had an outpatient service elsewhere, the Business Office Supervisor must follow-up with the facility, patient and/or fiscal intermediary in order to:
  - a. Determine if claims must be combined; and
  - b. Compile charges and ICD-9-CM coded diagnoses and procedures for the outpatient account meeting the criteria for the three-day window.
- Medical Records Department personnel must combine the inpatient and outpatient codes according to HHSC Policy No. PAT 1003, Medical Records: Coding and Documentation for Outpatient Services.
- 5. Business Office personnel must combine charges for submission of the inpatient claim.
- E. If an inpatient admission occurs within three days of an outpatient service performed in a physician's office that is wholly owned or operated by the admitting hospital (HHSC Policy No. FIN 0514, Outpatient Services and Medicare Three-Day Window (72-Hour Rule), the inpatient admission medical record is processed independently of the physician office visit.
  - 1. The inpatient admission must be:
    - a. Coded at the admitting hospital following HHSC Policy No. PAT 1003, Medical Records: Coding and Documentation for Inpatient Services;
    - b. Abstracted at the admitting hospital under the inpatient account number; and
    - c. Filed at the admitting hospital per the facility's inpatient record filing policy and procedure.
  - 2. The outpatient encounter from the physician office providing the outpatient services must be:
    - a. Coded at the physician office providing the outpatient service following physician office coding and documentation guidelines;
    - b. Abstracted at the physician office providing the outpatient service; and

- c. Filed at the physician office providing the outpatient service.
- 3. Determine if services must be combined on a single claim (technical component only); and
- 4. Compile charges and ICD-9-CM coded diagnoses and procedures for the services meeting the criteria for the three day window.
- F. Medical Records Department Personnel will notify the Business Office inpatient billing clerk if the inpatient and outpatient account have to be combined.
- G. On a daily basis, the Medical Records Department personnel must discuss the "Three-Day Window Report" with Admitting/Registration and Business Office personnel to determine if any patients have received outpatient services within the applicable "window." Communication between Medical Records, Admitting/Registration, and Business Office personnel must be established.
  - 1. Admitting/Registration personnel or Business Office personnel must communicate all occurrences of outpatient services provided within the "window" of an inpatient admission that meet the criteria as defined in HHSC Policy No. FIN 0514, Outpatient Services and Medicare Three-Day Window (72-Hour Rule).
  - 2. Medical Records Department personnel must review all accounts in the three-day window in order to provide the accurate sequencing of codes and DRG recalculation.
  - 3. As a component of the inpatient and outpatient medical record review for sequencing of codes and recalculation of the DRG, Medical Records Department personnel must review each of the identified cases (non-diagnostic or therapeutic outpatient services only) and determine if the diagnoses are related. If the ICD-9-CM principal diagnosis code for the outpatient non-diagnostic or therapeutic service is an exact match to the fifth digit level of the ICD-9-CM principal diagnosis code for the inpatient services must be considered "related" and Patient Accounting personnel must be informed to submit one combined (outpatient and inpatient charges) claim along with the order of sequence for the diagnosis and procedure codes and the DRG assignment. 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. Fiscal intermediary interpretations that vary from the exact match definition should be reported to the Director of Reimbursement.
- H. On a monthly basis, Medical Records and Business Office personnel must perform a remittance advice review of combined accounts to determine if claim rejections were due to inappropriate submission of documentation.
- I. The Medical Records Department, Admitting/Registration, and Business Office must develop a communication tool to monitor compliance with this policy.