



THE RIGHT CARE FOR EVERY PERSON EVERY TIME

Case Review Connection

The Medicare Quality Improvement Organization for Florida

Print this newsletter

Case Review Connection

Welcome to the second issue of our new newsletter for acute care hospitals. We hope that you will find the information useful and timely. If you have any suggestions for topics that you would like to see covered, please send an email to: mmunsch@flqio.sdps.org.

Please send this along to anyone in your organization that you think might benefit from the information. You can also subscribe by sending an email to: casereview@flqio.sdps.org.

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Coding Corner

Three-Day Payment Window Rules - Relationship to *Coding Clinic* Guidelines

History of Regulations

The 3-day payment window rules address two types of services:

- Diagnostic services
- Nondiagnostic (therapeutic services).

Explanation of these was originally provided in the *Medicare Hospital Manual*, under **Billing Procedures, 415.6 Outpatient Services Treated as Inpatient Services**. The instructions under **415.6** clarified billing of preadmission diagnostic services furnished on or after January 1, 1991. These instructions stated, "Diagnostic services (including clinical diagnostic laboratory tests) provided to the beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the hospital (or by another entity under arrangements with the hospital), within 3 days prior to the date of the beneficiary's admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage." The diagnostic services are defined by the presence on the bill of the revenue and/or HCPCS codes noted under **415.6**.

The instructions under **415.6** clarified billing of preadmission nondiagnostic outpatient services that are related to a patient's hospital admission. These instructions stated "Nondiagnostic outpatient services that are related to a patient's hospital admission and that are provided by the hospital, or by an entity wholly owned or operated by the hospital (or by another entity under arrangements with the hospital), to the patient during the 3 days immediately preceding the date of the patient's admission are deemed to be inpatient services and are included in the inpatient payment."

The aforementioned instruction in the *Medicare Hospital Manual* should now be referenced in the *Medicare Claims Processing Manual, Chapter 3, Inpatient Part A Hospital, Section 40.3 - Outpatient Services Treated as Inpatient Services*. While the *Medicare Hospital Manual* is still on the CMS Web site for reference purposes, it has been retired and should no longer be used as a resource for this information.) The *Medicare Claims Processing Manual, Section 40.3 B Preadmission Diagnostic Services (Effective for Services Furnished On Or After January 1, 1991)* clarifies billing of preadmission diagnostic services. It currently states, “Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital) within 3 days prior to and including the date of the beneficiary’s admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage.” The *Medicare Claims Processing Manual* had minor wording changes in section **40.3 B**, which was issued as a revision on October 21, 2005.

In **Section 40.3 C - Other Preadmission Services (Effective for Services Furnished On or After October 1, 1991)**, the manual clarifies billing of preadmission nondiagnostic services. It currently states, “Nondiagnostic outpatient services that are related to a patient’s hospital admission and that are provided by the hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), to the patient during the 3 days immediately preceding and including the date of the patient’s admission are deemed to be inpatient services and are included in the inpatient payment.” The *Medicare Claims Processing Manual* had wording changes in **section 40.3 C**, which were issued as a revision on October 21, 2005.

In order for providers to understand how to correctly bill nondiagnostic services, it is necessary to understand how Medicare defines “related.” The definition of “related” was published in the **final rule for Medicare Program: Payment for Preadmission Services**, in the **Federal Register, Vol. 63, No. 28**, February 11, 1998, on page 6866. This publication indicates, “We note that we have defined services as being related to the admission only when there is an exact match between the ICD-9-CM diagnosis code assigned for both the preadmission services and the inpatient stay.” This definition was effective March 13, 1998.

Medicare did not enable handling this exact match of diagnoses until July 1, 2003. In **CMS Transmittal A-03-013, Change Request 2573**, dated February 14, 2003, CMS establishes an implementation date of July 1, 2003 for changes to claims processing systems to support the new definition of “related.” The following definition, **which was effective March 13, 1998**, was provided:

- “...We defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay.”

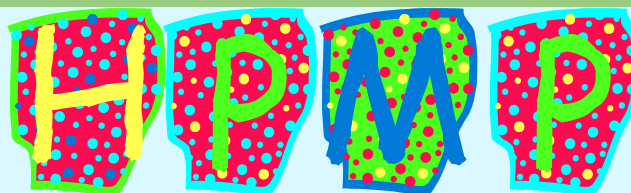
Please note that **CMS Transmittal A-03-054, Change Request 2803**, dated June 20, 2003, revises the revenue codes noted in CMS Transmittal A-03-013.

On October 21, 2005, the definition of “related” was issued as a revision to the *Medicare Claims Processing Manual, Chapter 3, Inpatient Part A Hospital, Section 40.3—Outpatient Services Treated As Inpatient Services, C-Other Preadmission Services (Effective for Services Furnished On or After October 1, 1991)*. It states, “Effective March 13, 1998, we defined nondiagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay.” It goes on to say, “Thus, whenever Part A covers an admission, the hospital may bill nondiagnostic services only if they are not related to the admission. The FI should assume, in the absence of evidence to the contrary, that such bills are not admission related and, therefore, are not deemed to be inpatient (Part A) services.”

A discharge need not occur between the outpatient nondiagnostic service and the inpatient admission for the Medicare 3-day payment window provision to be applicable.

Although *Coding Clinic* would advise coders in certain instances to include services in coding that are completed prior to the admission, the Medicare 3-day payment window provision stipulates that certain services would not be included, unless there is an exact match between the principal diagnosis code assigned for both the preadmission services and the inpatient stay. Remember, *Coding Clinic* provides coding advice. The “3-Day Payment Window” is a separate Medicare billing requirement that providers must follow in order to receive reimbursement. *Coding Clinic* addresses discrepancies between coding guidelines and payer policies such as those posed by the issued previously described, in *Coding Clinic, Third Quarter 2000*, pages 13-15.

Sometimes an outpatient account correctly submitted separately from an inpatient admission that occurred within the 3-day payment window will be rejected by the FI and the provider assumes that the accounts should be combined onto one claim. This may or may not be the case. Make sure to read the FI edit and review the account(s) carefully prior to combining them. Accounts that are not bundled totally appropriately will reject. For instance, if a nondiagnostic outpatient procedure meets the criteria listed above to be submitted on an outpatient claim and a diagnostic service revenue code is inadvertently left on the outpatient claim instead of being moved to the inpatient claim, the whole outpatient claim will reject. Removing the diagnostic revenue code from the outpatient claim and resubmitting the claim with only the nondiagnostic service information will allow the claim to be paid.



HPMP Updates

Top 20 DRGs—Short-Term Acute-Care Hospitals

The below link provides a listing of the top 20 DRGs by volume of discharges for one-day stays for short-term, acute-care, PPS hospitals. The data are aggregated at the national level. One-day stays occur when a patient is admitted as an inpatient on one day and discharged either the same day or on the following day. When the patient dies, leaves against medical advice, or is transferred to another short-term acute-care PPS hospital (patient status codes 20, 07, or 02), these claims are not included in the data. These data represent discharges occurring in FY 2006 through the third quarter (October 1, 2005 through June 30, 2006).

Top 50 DRGs—Long-Term Acute-Care Hospitals

The below link provides a listing of the top 50 DRGs by volume of discharges for long-term acute-care hospitals. The data are aggregated at the national level. The data include the number of discharges, the average length of stay for each DRG, and number and percentage of discharges that are short-stay outliers for FY 2006 through the third quarter (October 1, 2005 through June 30, 2006).

Target Area Analysis—Short-Term, Acute-Care Hospitals

The below link provides national-level statistics for areas identified as at-risk for payment errors in short-term acute-care hospitals. The data include number of discharges for the numerator and denominator for each target area, proportion for each target area, average payment for a claim for each target area, and the sum of total payments for each target area. For more information on the areas identified as at-risk for payment errors, please see the Short-Term PEPPER User's Guide.

[Click Here](#)

Target Area Analysis—Long-Term, Acute-Care Hospitals

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[Click Here](#)



HINN Updates

Just a reminder regarding the issuance of a Hospital Issued Notice of Noncoverage/Hospital Advanced Beneficiary Notice. At our website, www.fmqai.com, you can find the model letters for the Notices by clicking on the *Providers* tab and then *Case Review* and then *Download Publications, HINN book*. Please update your templates to reflect the correct Name and Address for the QIO. Also, all parenthetical references and footnotes are to be removed from the final letter given to the beneficiary.

For assistance, please call Yvette Cook at extension 3516.

IMPORTANT: The final rule which sets forth requirements for how hospitals must notify Medicare beneficiaries who are hospital inpatients about their hospital discharge rights has been published. Notice will be required for both original Medicare beneficiaries and for beneficiaries enrolled in Medicare Advantage (MA) plans and other Medicare health plans which are subject to the MA regulations, effective July 1, 2007. Briefly the rule states: "...Hospitals will use a revised version of the Important Message from Medicare (IM)...to explain the discharge rights. Hospitals must issue the IM within 2 days of admission, and must obtain the signature of the beneficiary or his or her representative. Hospitals will also deliver a copy of the signed notice prior to discharge, but not more than 2 days before the discharge. For beneficiaries who request an appeal, the hospital will deliver a more detailed notice..."

For the complete publication of this rule, please go to the [Federal Register](#).



ADR

Please visit our website at www.fmqai.com for updated information about the alternative dispute resolution process. Click on Professionals/Providers, Case Review, Types of Reviews, Beneficiary Complaints and Alternative Dispute Resolution.

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