FACTS & FEATURES

AHA SERVICES
Guiding Healthcare Solutions

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What Coders Should Know about the Medicare 3-Day Payment Window

FHA Florida Hospital Association Management Corporation

The 3-Day Payment Window was previously known as the "72-hour rule." The following is an excerpt from the ***Implementation of New Statutory Provision Pertaining to Medicare 3-Day (1-Day) Payment Window Policy – Outpatient Services Treated As Inpatient*** available on the *CMS.gov* website.

> On June 25, 2010, President Obama signed into law the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010," Pub. L. 111-192. Section 102 of the law pertains to Medicare's policy for payment of outpatient services provided on either the date of a beneficiary's admission or during the three calendar days immediately preceding the date of a beneficiary's inpatient admission to a "subsection (d) hospital" subject to the inpatient prospective payment system, "IPPS" (or during the one calendar day immediately preceding the date of a beneficiary's inpatient admission to a non-subsection (d) hospital). This policy is known as the "3-day (or 1-day) payment window." Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) ***must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the beneficiary during the 3-day (or 1-day) payment window.*** The new law makes the policy pertaining to admission-related outpatient non-diagnostic services more consistent with common hospital billing practices and makes no changes to the existing policy regarding billing of outpatient diagnostic services. Section 102 of Pub. L. 111-192 is effective for services furnished on or after the date of enactment, June 25, 2010.

What changed and what didn't change?

Prior to the enactment of this new rule, all diagnostic service performed within the 3 days prior to the inpatient admission were required to be billed on the inpatient admission (under the DRG payment system). This did not change. What did change is the definition of "admission-related outpatient non-diagnostic" services. Before June 25, 2010, the definition applied to determine if the non-diagnostic services such as 45X, 75X, 76X and 36X revenue code (revenue code tells an insurance company whether the procedure was performed in the emergency room, operating room or another department) services was an "exact match of the principal/primary diagnosis codes" between the inpatient admission and the non-diagnostic service.

The new definition of "admission-related" is whether or not the services provided were "clinically related" to the inpatient admission. If they are clinically related, then the non-diagnostic service along with the related diagnoses must be moved to the inpatient claim.

Continued

AHA Webinar:

AHA Services will host a free webinar with Class Action Capital – 2pm CST March 28th – to introduce the refund opportunities to its members. During the webinar, Class Action Capital will share the most important points of the settlement opportunities, explain the claims process and answer any questions.

Click here to register

Questions? Contact John Borley, *john@classactioncapital.com* or 914.200.0020

What's inside:

What Coders Should Know, continued from page 1

Also, all services provided on the same day as the date of admission, whether diagnostic or non-diagnostic, must be billed on the inpatient claim along with all the related diagnoses for the outpatient services.

Who determines whether the outpatient non-diagnostic services are "clinically-related" to the inpatient admission?

Determining whether outpatient services are related to the inpatient admission is best determined by an inpatient coder after the patient has been discharged from the inpatient admission and with complete documentation on both the outpatient and inpatient encounters. The inpatient coder would have the knowledge and coding skills to determine if the two or more encounters were clinically related to the inpatient admission. For instance, a patient who comes in to the ER two days prior to an inpatient admission with right upper quadrant abdominal pain as their final diagnosis is admitted to the hospital and undergoes cholecystectomy. The coder would be able to determine from the documentation that these two encounters are "clinically related."

Once the encounters have been determined to be "clinically related," coders have more work to do. All non-diagnostic procedures will need to be recoded using ICD-10-PCS because they will now appear on the inpatient claim. All significant diagnoses, Comorbid Conditions (CCs) and Major Comorbid Conditions (MCCs) from the outpatient encounter will also need to be moved to the inpatient encounter. And some sort of notification will need to appear in the inpatient electronic medical record which indicates which encounters were combined and by whom. This is a very important step. When the record is requested for an audit, the facility wants to assure that all of the related clinical documentation is provided to the reviewer to support the claim.

Lastly, all the diagnostic charges must be moved to the inpatient claim and the billing office will need to be notified when the inpatient claim has been updated to include the prior outpatient charges and codes so that they can submit the inpatient claim.

What if the inpatient coder determines that the non-diagnostic services are not "clinically related" to the inpatient admission?

If the coder determines that the non-diagnostic services provided are not related, an outpatient claim for the non-diagnostic services alone may be submitted. The facility is required to maintain documentation in the beneficiary's medical record to support their claim that the preadmission outpatient non-diagnostic services are unrelated to the beneficiary's inpatient admission.

Still, all diagnostic services provided within 3 calendar days must be billed on the inpatient claim. Only the non-diagnostic services and revenue codes may be billed separate from the inpatient admission. The outpatient and inpatient coder should assure that charges have been moved to the correct account and that the inpatient and outpatient accounts are coded correctly before sending notification to the billing office that the claims are ready for billing.

Lessons to be learned

Over the years, facilities have tried combining accounts to comply with the 72-hour rule through the use of automation or by simply combining every charge and service within 72-hours to the inpatient encounter. Although combining everything may have kept the facilities off of CMS's radar for non-compliance, it also resulted in a significant loss of revenue that was due to the facilities. Coding and billing compliance is defined as complete compliance with the billing regulations and receiving appropriate payment for the services rendered. Compliance with the 3-day payment window involves many departments working together to produce a clean claim.

For more information contact Barbara J. Flynn, RHIA, CCS, Vice President, Health Information and Denial Management Services, Florida Hospital Association Management Corporation, 407.841.6230, *barbaraf@fha.org*

Health Information and Denial Management Services Provides the following services:

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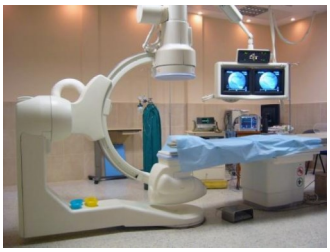
AHA Services Announces New Partnership with Remi - *The Proven Alternative to Traditional Equipment Service Agreements*



Have you been continually renewing the Original Equipment Manufacturer (OEM) service agreements simply because it's been the norm? Do you feel like you have gotten what you've paid for over the course of the agreement? Maybe it's time to reevaluate your needs, weigh other options and possibly save hundreds of thousands of dollars on equipment maintenance agreements.

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For more information visit *www.theremigroup.com* or contact Mike Marquette, Director Healthcare Practice, at 262.565.5746 or *mmarquette@theremigroup.com*.

340B Day

Arkansas Hospital Association

March 20, 2017

9:00 a.m. to 4:00 p.m.

Click *Register* for Agenda and registration brochure

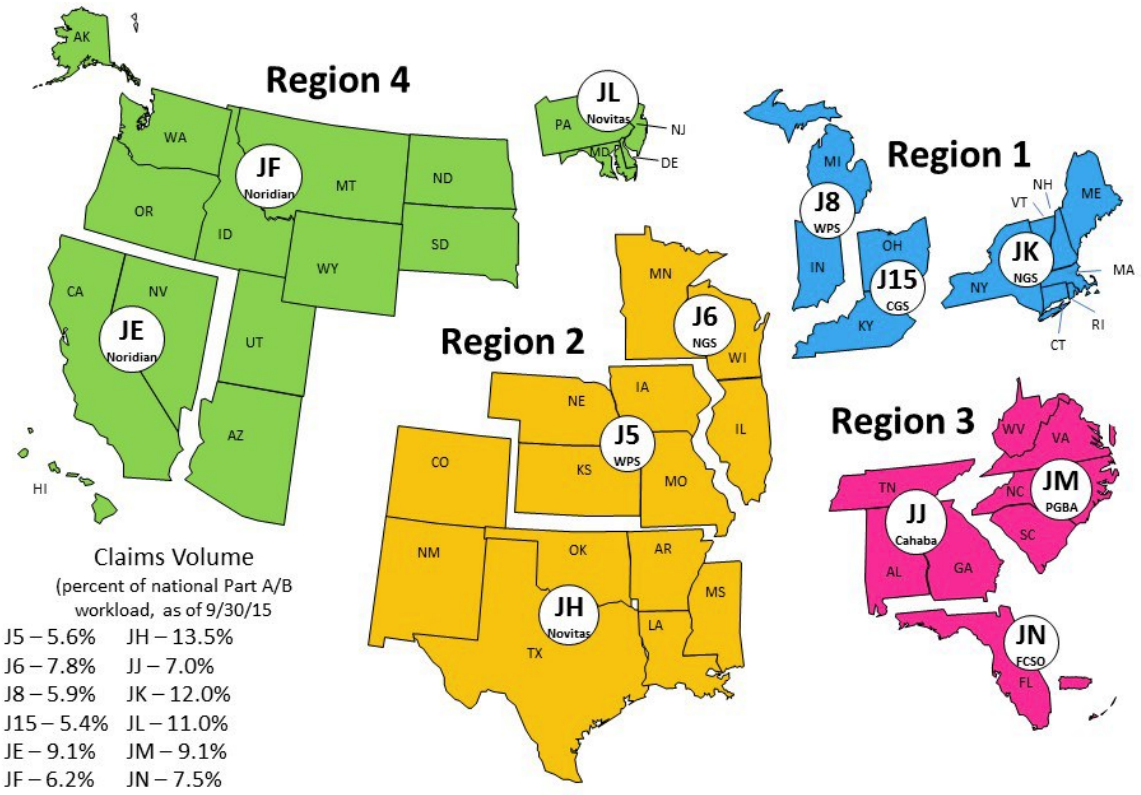
For more information contact Tina Creel, *tcreel@arkhospitals.org* or Liz Carder, *lcarder@arkhospitals.org*

New RAC Issues Approved: AUDIT TRAX System Can Help

In October of 2016, CMS awarded new Recovery Audit contracts, and there are now 5 regions within the United States (see map below). Arkansas is now part of Region 2, which is covered by *Cotiviti* LLC. The focus will include post-payment review of Medicare Part A and B claims for all provider types excluding durable medical equipment, prosthetics, orthotics, supplies and home health and hospice.

With the new CMS RAC contracts, a number of changes have occurred. First, the RAC contractor payment timeline has been extended from the original 45 days to a time following a provider's challenge passing the second level appeal process. Another change is that the original three-year claim lookback window has been reduced for medical necessity claims, which will now be six months. The original lookback period of three years would still apply to other types of RAC claim review.

Within the past two months, there have been a significant number of newly approved CMS audit issues which will soon translate into new RAC audit activity at AHA member facilities *(click here for full list)*. Now is an ideal time for all providers to reconvene your RAC Teams to review the approved CMS audit issues, and to review your procedures and timelines for responding to RAC audits. A great way to manage RAC and all audits is to have a workflow management tool that can assist in automating the workflow and managing deadlines. AHA Services is pleased to endorse *AUDIT TRAX*, a comprehensive and affordable audit tracking tool that helps you maintain control of the complex RAC process.



For more information on AUDIT TRAX, please contact Timothy Keough, VP NJHA-HBS Information Services, 609.936.2222 or *tkeough@njha.com*.

The Threat of In-House Wellness Programs

Fact: Hospitals are the undisputed leaders in health care.

Which begs the question, "Why don't those leaders take care of themselves and take charge of their own health?" Unfortunately, it is not for lack of education or understanding. There is a lack of motivation, time, or priority.

Which brings other questions: How do you encourage healthy behaviors in health experts? Is your hospital's wellness program effectively carrying out your goal of improving your team's health and wellness, while mitigating risk, minimizing healthcare expense and improving employee retention and productivity?

The fact is, there is no perfect formula for a successful hospital wellness program. But these are the 3 most common issues that can derail an employee wellness program:

1 - A Wellness Program that is entirely carried out by your hospital staff.

Does it save money? Possibly. Is it realistic? That depends on the number of employees and satellite clinics your hospital has and how dynamic your team is. Does it set up the picture-perfect scenario for a disgruntled employee wrongful termination lawsuit? You bet. The "iron curtain" between the HR office and wellness program data do not always appear to be "iron clad" to employees, diminishing some employees' trust in the in-house programs. In addition, the EEOC and Department of Labor continue to be advocates for employees who claim to fall victim to employer-sponsored wellness programs.

Best case: Let someone else manage the biometric and health risk assessment data to reduce the risk of lawsuits, help with employee engagement events and/or provide health coaching to your staff.

2 - Hiring a multitude of vendors to carry out their cookie-cutter wellness programs.

Multiple vendors providing wellness coaches, data mining programs, and EAP groups who don't communicate with one another can be a recipe for disaster. Not only can multiple messages confuse employees, these uncoordinated efforts might dilute each program's effectiveness. Another issue is senior leadership can simply check the wellness box and move on with all of their other responsibilities, forgetting to reinforce the wellness message to their team members.

Best case: Establish a lead vendor who can coordinate efforts of your hospital staff and other vendors to ensure that employees receive clear and coordinated messaging to encourage healthy behaviors.

3 - Setting up unrealistic expectations

Employee wellness programs are an ongoing process. As the workforce turns over, perhaps people leave for another job or retained employees advance in the stages of life, the wellness needs of your team will also change. An effective wellness program will be adaptable to shifting needs of your team, but results will take 2 to 3 years to be realized.

The TRS/Wellness advice? The best kind of wellness that can be implemented for hospital employees is one where the program is specifically designed for the hospital's culture. TRS/Wellness likes to function as the hub that keeps the wellness program moving in the right direction, working alongside your in-house team as well as with other vendors to ensure that your team is getting the best outcomes. TRS/Wellness also works well with the employee health team to reduce on-the-job injuries.

TRS/Wellness prides itself on injury and illness prevention, providing in-depth ergonomics, functional job analyses, return-to-work programs, behavior-based health coaching, employee engagement/education events and comprehensive biometric testing as its wellness specialties. Because TRS/Wellness is a health care-derived company, individualizing its specialties for a single group has become an art. This will allow you to focus on the health care of your patients while focusing on improving the well-being of your health care providers.

For more information contact Jackie Bracey, 501.358.6016 or *jbracey@trswellness.com*.

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AHA Workers' Compensation Self-Insured Trust

14th Annual Education Conference

November 16, 2017

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For more information contact Liz Carder,
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