PATIENT ACCOUNTS
NEW POLICIES

Policy Number	Policy Title
403.00	Medicare Part A to B Rebilling
402.00	Medicare Three Day Payment Window
404.00	Medicare Pre-Entitlement Billing

SECTION: Patient Accounts **SUB SECTION:** Billing Procedures

SUBJECT: Medicare Part A to B Rebilling

APPROVED BY: Genaro Grajeda
Administrative Supervisor, Patient Accounts

I. POLICY:

A. The purpose of this policy is to ensure compliance with CMS regulations and the requirements for Medicare Part A to B rebilling.

II. PART A TO B REQUIREMENTS:

A. Effective for admissions on or after October 1, 2013, Medicare has a fully implemented process for allowing Part B of A services when:

1. Claims are denied as not reasonable and necessary
2. Utilization Review (UR) Committee performs a self-audit and determines account does not meet inpatient criteria.

III. PROCESS:

A. Acute inpatient claims denied as not reasonable and necessary with a valid inpatient order:

1. First determine if UR Committee agrees or disagrees with claim denial
    a. Medicare billers will forward all denied acute inpatient claims with a valid inpatient order to UR Committee for review
2. If UR Committee disagrees with denial:
    a. Billers will request additional documentation/diagnosis information from medical records department
    b. Submit Redetermination to Noridian
    c. Providers have 120 days from claim denial date to submit Redeterminations
        i. Do not submit ancillary claims if UR Committee disagrees with denial as this will waive provider appeal rights
3. If UR Committee agrees with denial:
    a. Billers will submit a 12X TOB claim for services that would have been payable had the beneficiary originally been treated as an outpatient
        i. Report date of admission through discharge on 12X claim
    b. Billers will also submit a separate 13X TOB claim for outpatient services rendered within the payment windows prior to admission
4. Billing Process for 12X TOB:
    a. In Treatment Authorization field: A/B Billing
    b. Remarks field: ABREBILL12345678901234
    c. Condition Code: W2

d. Services not billable on 12X TOB:
    i. Outpatient visits with revenue codes 45X and 51X
        1. This includes CPT/HCPCS codes G0378 and G0379, 99201-99215, 99281-99285, G0380-G0384 and G0463
    ii. Observation Services with revenue code 0762
    iii. Services not covered under Part B
        1. Example: Room & Board revenue codes 0100-0239
    iv. Diabetes Self-Management Training (DSMT)

5. Billing Process for 13X TOB:
    a. Submit outpatient services provided during the three/one day payment window before admission
        i. Examples: ED Department, Observation, Surgery
    b. No treatment authorization, remarks or condition codes are required on the 13X TOB
6. Both TOBs 12X and 13X can be billed simultaneously, 12X does not have to be finalized before billing TOB 13X
7. Make sure all claims billed have same discharge status listed
8. If claim is identified as not meeting inpatient criteria before it has been billed, billers will follow the self-audit process outlined below before submitting 12X or 13X TOBs.

B. Self-audited acute inpatient accounts that do not meet inpatient criteria after discharge with a valid inpatient order:

1. This allows for the facility to bill for accounts that have already been discharged when the UR committee determines the acute inpatient admission was not reasonable and necessary
2. To assist in identifying accounts that do not meet inpatient criteria after discharge, Medicare billers will forward all one-day stay acute inpatient accounts with a valid inpatient order to the UR Committee for review before billing
3. Billing Process for accounts that do not meet inpatient criteria after UR Committee review:
    a. Billers will submit self-denial inpatient TOB 110 with the following criteria:
        i. Condition Code 21: BILLING FOR DENIAL NOTICE
        ii. Non-covered days with Value Code 81
        iii. Services from admission through discharge
        iv. The appropriate patient discharge status
        v. Occurrence Span Code M1 and dates of services
        vi. Non-covered charges for all services rendered
        vii. All diagnosis codes
        viii. All procedure codes
        ix. Remarks indicating the claim has been self-audited by facility and the claim did not meet inpatient criteria
    b. Any previously paid 11X TOBs must be adjusted as a "no pay" claim following the steps above if the claim is self-audited after initial billing

c. Once the "no pay" claim is finalized, billers can submit all A/B rebilling claims which are outlined above in section A, 4&5

C. Acute inpatient accounts with invalid/missing admission orders:
   1. Room and Board charges not allowed to be billed without a valid/active physician inpatient order even if the UR Committee determines that account meets inpatient criteria
      a. The physician order must have a valid signature to be considered active
   2. Account must be switched to OBS account type and billed as an outpatient claim since the patient was never considered to be an inpatient of the facility
   3. TOB 13X submitted, existing OBS billing process will be followed by Medicare billers

D. In-house acute inpatient accounts that are identified by UR Committee as not meeting inpatient criteria before discharge:
   1. UR Committee will notify physician and order will be switched to OBS
   2. Account will be switched to OBS by registration
   3. Medicare billers will append Condition Code 44 to OBS claim
      a. Billers can locate modifier on UR Screen under comments

E. Self-audited acute inpatient accounts that do not meet inpatient criteria after discharge with a valid inpatient order with a beneficiary who does not have Part A Benefits:

   1. Account is switched to IP MCRB
      a. TOBs 12X and 13X are billed following the process outlined above
      b. Remaining balance on account is written off, not billed to secondary since account does not meet inpatient criteria

REFERENCES: CMS 1599-F, CR 8445, CR 8446

DEFINITIONS: N/A

ATTACHMENTS: N/A

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
1/14/2019	**Genaro Grajeda** Administrative Supervisor, Patient Accounts
	Arvind Oswal Chief Financial Officer
	Board of Supervisors Approved by the Governing Body

REPLACES: N/A

EFFECTIVE: 11/1/2017 **REVISED: N/A**

REVIEWED: 1/1/2019

SECTION: Patient Accounts **SUB SECTION:** Billing Procedures

SUBJECT: Medicare Three Day Payment Window

APPROVED BY: Genaro Grajeda
Administrative Supervisor, Patient Accounts

I. POLICY:

A. The purpose of this policy is to ensure compliance with the Medicare requirements for the bundling of certain medical services.

II. BUNDLING REQUIREMENTS:

A. Medicare requires the bundling of most non-physician services furnished by an IPPS hospital within three (3) days prior to the date of an inpatient admission or of other outpatient services rendered. This rule is known as the "DRG 3-Day Payment Window".

III. PROCESS:

A. Printing the Medicare 3-Day Report

1. In the Meditech system on the main menu page under "Patient Accounts – BARCASH" select → B/AR Menu → Inpt/Outpt Exception Report
2. On the 'Inpt/Outpt Exception Report' screen, in the "*From Admission Date" field, enter T-14 → in the "*Thru Admission Date" field, enter T → in the "*Insurance" field, enter MCR → in the "*Account Type" field – first line, enter I INP, second line, enter I PSY → in the "*Suppress Zero Balance Visits" field through "*Outpatient With Prior Visits" field, enter Y → Click on OK
3. On the 'Print Destination' screen, Click on Preview → Click on OK
4. On the 'Inpatient/Outpatient Exception Report' screen, Click on printer icon → in the pop up window, Click on OK
5. Review overlapping accounts listed on the report and proceed with billing the accounts according to the guidance below.

B. DSG Edits

1. DSG also has an edit to ensure overlapping claims are not billed to MCR:
   a. 19*14 STATEMENT THRU DATE - CLAIM OVERLAPS WITH ANOTHER CLAIM
2. When this edit appears on the claim, review overlapping accounts and proceed with billing the accounts according to the guidance below.

IV. IDENTIFYING OUTPATIENT ACCOUNT SERVICE TYPES THAT ARE 3 DAYS OR LESS FROM AN INPATIENT ADMISSION:

A. If the account charges occur on the **same date of service** as the inpatient admission, all charges must be moved to the inpatient account and billed together;

B. If the account charges occur 1, 2, or 3 days prior to IP admission and are **clinically related**, all charges must be moved to the inpatient account and billed together;

C. If the account charges occur 1, 2, or 3 days prior to IP admission and are **not clinically related**, move all diagnostic services performed during the outpatient visit to the inpatient account (if any) and append modifier 51 to the updated outpatient claim. See chart below to help in identifying which revenue codes are considered to be "diagnostic";

D. If the account charges occur 1, 2, or 3 days prior to IP admission and are **not clinically related but all charges are considered to be diagnostic**, all charges must be moved to the inpatient account and billed together;

E. If billers are unclear on the nature of the accounts and/or if they are to be considered clinically related, they should forward the accounts in question to their immediate supervisor for review before billing to make sure compliance is met.

V. DIAGNOSTIC SERVICES REVENUE CODES AND DEFINITIONS:

0254	0255	030X	031X
032X	0341	035X	0371
0372	040X	046X	0471
048X	053X	061X	062X
073X	074X	092X	

REVENUE CODES	DESCRIPTION	REVENUE CODES	DESCRIPTION
0254	Drugs incident to other diagnostic services	0471	Audiology diagnostic
0255	Drugs incident to radiology	0481, 0489	Cardiology, Cardiac Catheter Lab/Other Cardiology with CPT codes 93501,93503.93505,93508,93510,93526, 93541,93542,93543,93544.93556,93561, or 93562 diagnostic
030X	Laboratory	0482	Cardiology, Stress test
031X	Laboratory pathological	0483	Cardiology, Echocardiology
032X	Radiology diagnostic	053X	Osteopathic services
0341, 0343	Nuclear medicine, diagnostic/Diagnostic Radiopharmaceuticals	061X	MRT

035X	CT scan	062X	Medical/surgical supplies, incident to radiology or other diagnostic services
0371	Anesthesia incident to Radiology	073X	EKG/ECG
0372	Anesthesia incident to other diagnostic services	074X	EEG
040X	Other imaging services	0918	Testing – Behavioral Health
046X	Pulmonary function	092X	Other diagnostic services

VI. **POLICY RECAP:**

If outpatient services are....	**And outpatient line item date of service is....**	**Then.....**
Diagnostic and/or Non-Diagnostic, related or non-related	**Same day as IP**	Move OP diagnosis codes, procedures codes and charges to IP account
Diagnostic and/or Non-diagnostic, **related to IP**	1, 2, or 3 days prior to IP	Move OP diagnosis codes, procedures codes and charges to IP account
Charges **not related** to IP	1, 2, or 3 days prior to IP	Move all diagnostic charges to IP Account, leave OP diagnosis codes, procedure codes and all other charges on OP account. Medical record must support "not related" decision. Additionally, Condition Code 51 must be reported.
Diagnostic charges only, charges **not related** to IP	1, 2, or 3 days prior to IP	Move to OP diagnosis codes, procedure codes and charges to IP account

REFERENCES: N/A

DEFINITIONS: N/A

ATTACHMENTS: N/A

APPROVAL DATE:

N/A	**Policy, Procedure and Standards Committee**
1/14/2019	**Genaro Grajeda** Administrative Supervisor, Patient Accounts
	Arvind Oswal Chief Financial Officer
	Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

EFFECTIVE: **8/1/2016** **REVISED:** **N/A**

REVIEWED: **1/14/2019**

SECTION: Patient Accounts **SUB SECTION:** Billing Procedures

SUBJECT: Medicare Pre-Entitlement Billing

APPROVED BY: Genaro Grajeda
Administrative Supervisor, Patient Accounts

I. POLICY:

A. The purpose of this policy is to ensure compliance with CMS regulations and the requirements for Medicare Pre-Entitlement billing for Inpatient accounts.

II. PRE-ENTITLEMENT DEFINITION & COVERAGE:

A. Medicare Pre-Entitlement exists when a beneficiary is admitted to an acute-care hospital stay prior to the beneficiary's Medicare Part A entitlement effective date.

B. The number of utilization days is calculated from the Medicare entitlement date through discharge/transfer/death.

C. For providers subject to the Inpatient PPS (Prospective Payment System), the DRG (Diagnosis Related Grouping) will be calculated from the date of admission through the date of discharge/transfer/death.

D. The outlined process below should be followed when an Inpatient account is identified as having pre-entitlement benefits and Medicare is not determined to be secondary to any other type of primary insurance (MSP). In this case, the primary payer is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract and billers should follow normal MSP billing procedures.

III. PROCESS:

A. Admit to Discharge Claims:

1. Type of claim: 111
2. The claim must be submitted as follows:
    a. Original admission date should be added to form locator (UB-04 FL 12)
        i. The date the patient was formally admitted as an inpatient
    b. Statement Covered Period From Date (UB-04 FL 6) equal to the effective date of Medicare coverage
    c. Statement Covered Period Through Date (UB-04 FL 6) equal to the end date of the stay
    d. Covered days with Value Code 80 (UB-04 FL 39-41) should equal the from and through date span of the covered days
        i. Non-covered value codes are not reported

e. Accommodation days/units (Room and Board Revenue Codes 010x through 016X) (UB-04 FL 42 and FL 46) equal to the covered days reported with Value Code 80
    i. Charges for room and board should only include the time the patient was entitled to Medicare Part A benefits
    ii. Do not report non-covered room and board charges for the time frame the patient was not entitled to Medicare Part A benefits
    iii. Billers will add excluded room & board charges to a write-off sheet using the following adjustment code: AMCR
f. Include ALL diagnosis codes (UB-04 FL 66) from admission date to discharge/transfer/death
g. Include ALL surgical procedures (UB-04 FL 74) performed from the admission to discharge/transfer/death
h. Add Remarks (UB-04 FL 80) indicating the date Medicare Part A entitlement started.

B. Interim Billing Claims

1. Type of claim with either be 112 or 113
2. The claim must be submitted as follows:
    a. Original admission date should be added to form locator (UB-04 FL 12)
        i. The date the patient was formally admitted as an inpatient
    b. Statement Covered Period From Date (UB-04 FL 6) equal to the effective date of Medicare coverage
    c. Statement Covered Period Through Date (UB-04 FL 6) equal to the end date of interim bill
    d. Covered days with Value Code 80 (UB-04 FL 39-41) should equal the should equal the from and through date span of the covered days
        i. Non-covered value codes are not reported
    e. Accommodation days/units (Room and Board Revenue Codes 010x through 016X) (UB-04 FL 42 and FL 46) equal to the covered days amount reported in value code 80
        i. Charges for room and board should only include the time the patient was entitled to Part A
        ii. Do not report non-covered room and board charges for the time frame the patient was not entitled to Part A
        iii. Billers will add excluded room & board charges to a write-off sheet using the following adjustment code: AMCR
    f. Include ALL diagnosis codes (UB-04 FL 66) from admission date to discharge/transfer/death
    g. Include ALL surgical procedures (UB-04 FL 74) performed from the admission to discharge/transfer/death
    h. Add Remarks (UB-04 FL 80) indicating the date Medicare Part A entitlement started.

IV. BILLING EXAMPLE:

A. Example 1: Patient admitted on 01/15/18 and discharged on 02/25/18. The patient is not entitled to Medicare Part A until 02/01/18. This claim should be billed as follows:

1. Bill type 11X
2. Admission Date: 1/15/18
3. Statement covers from and through date: 2/1/18-2/25/18
4. Covered days: 24
    a. Accommodation (R&B rev codes) days/units: 24 units x daily rate
5. Remarks: Medicare Part A effective 2/1/18

V. ADDITIONAL INFORMATION:

A. Providers may not bill the beneficiary or other persons for days of care preceding entitlement.

B. Medicare will pay claim based on DRG.

C. Do not submit a claim for the pre-entitled days to the patient or patients other health coverage as a primary bill as this would be considered duplicate billing.

D. Claims with a discharge date equal to the effective date of Medicare coverage cannot be billed as a Pre-Entitlement claim and should be billed to the appropriate Payor to which the patient had coverage during stay.

REFERENCES: **Internet Only Manual (IOM) 100-04, Chapter 3, Section 40**
https://med.noridianmedicare.com/web/jea/provider-types/acute-ipps-hospital/pre-entitlement-claims

DEFINITIONS: **MSP: Medicare Secondary Payor**
FL: Form Locator

ATTACHMENTS: **N/A**

APPROVAL DATE:	**N/A**	**Policy, Procedure and Standards Committee**
	1/14/2019	**Genaro Grajeda** Administrative Supervisor, Patient Accounts
		Arvind Oswal Chief Financial Officer
		Board of Supervisors Approved by the Governing Body

REPLACES: **N/A**

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REVIEWED: **1/1/2019**