

# BAPTIST HEALTHCARE SYSTEM

CATEGORY Compliance	EFFECTIVE DATE Nov. 1, 1999	REVISED  7/03
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## SYSTEM POLICY AND PROCEDURES

**SUBJECT:** Protocol for Medicare 72-Hour Regulation

**STANDARD(S) OF CONDUCT:** The business of BHS will be conducted according to all applicable laws.

**SCOPE:** This policy applies to employees of the Patient Accounting Departments of the Baptist Healthcare System whose jobs ensure that all claims are billed correctly to Medicare to avoid denials for inpatient/outpatient overlap.

**AUTHORIZATION:** Directors of Patient Accounting at all Baptist Healthcare System facilities are responsible for the administration of the policy.

### PURPOSE / COMPLIANCE OBJECTIVE

The purpose of this policy is to implement procedures to ensure that all claims are billed correctly to Medicare to avoid denials for inpatient/outpatient overlap.

### PROTOCOL / PROCEDURES

When a beneficiary receives outpatient hospital services the day immediately preceding the inpatient admission, ALL charges should be transferred to the inpatient account (providing the beneficiary has PART A coverage).

Diagnostic services provided within three days prior to the date of the inpatient admission should be transferred to the inpatient account, unless there is no Part A coverage. (For example, the patient is admitted on Wednesday – diagnostic services provided on Sunday, Monday, or Tuesday would be included on inpatient bill.)

Outpatient services provided within three days of the inpatient admission should be transferred, IF they are related (check diagnosis).

Examples:

- Patient comes into ER Sunday for broken foot. Patient comes back Wednesday and admitted for CHF. The ER charge DOES NOT have to be transferred to the inpatient, because it is a non-diagnostic charge and IS NOT related to CHF.
- Patient comes into ER Sunday for chest pain. Patient comes back Wednesday for CHF. ALL charges must be transferred to the inpatient account.

Diagnostic services are defined by the presence of the following revenue codes:

254, 255, 30X, 31X, 32X, 341, 35X, 40X 46X, 53X, 61X, 62X, 73X, 74X, 92X, 48X with these HCPC's: 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544 – 93552, 93562.

(Refer to section 415.6 in Medicare Hospital Billing Procedures.)

1. The Admission/Registration Report (CRR020AL) is used to identify all Medicare inpatients admitted daily except Saturday and Sunday which may be done on Monday. The patient name/number look up should be checked to see if any outpatient accounts need to be transferred to the inpatient account.

The following reports should also be worked daily (except weekends, which may be worked on Monday) to identify overlapping accounts that may be created after the initial admission or registration. The overlapping accounts identified with aid from these reports will not be reflected on the Admission/Registration report.

The Admission/Discharge Date Correction Report (CRR014) is used to identify changes to the admission or discharge date of an account. Each Medicare inpatient should be checked to see if the date change has created an overlap with an outpatient account that, as a result, needs to be transferred to the inpatient account. The account should also be checked to see if an outpatient account was transferred to it before the date change that no longer overlaps since the date change. If so, this transfer should be reversed.

The Transfer to Patient Type "I" Report (TPR9020B) is used to identify accounts that have been changed to an inpatient status. Each Medicare inpatient should be checked to see if the status change creates an overlap with an outpatient account that, as a result, needs to be transferred to the inpatient account. The account should also be checked to see if, while it was an outpatient account, any of its charges were transferred to an inpatient account with which it overlapped. If so, this transfer should be reversed.

The Transfers from Patient Type "I" Report (TPR9010B) is used to identify accounts that have been changed from an inpatient status. Each Medicare outpatient should be checked to see if the status change creates an overlap with an inpatient account that, as a result, requires the outpatient account to be transferred to the inpatient account. The account should also be checked to see if, while it was an inpatient account, an overlapping outpatient account was transferred to it. If so, this transfer should be reversed.

2. If all charges are transferred to the inpatient account, the “Bill-To” function should be used. (See “Bill To” procedure). If only diagnostic charges are transferred, submit appropriate paper work to have charges moved.

If there is a recurring account, this account should be discharged. The Medicare Account Representative will check to see if the invoice period has closed for the month of the last charge – if it has, the bill will produce correctly. If the invoice period has not closed for the month of the last charge, the media will be changed to paper and the account watched. When the paper claim produces, the date of service will need to be changed to avoid overlap.

3. If the biller has a recurring account reject on the Medicare remit, check to see if the account needs to be billed for the exact dates of service; if so, request the bill. If the account cannot be billed for exact dates of service, the Medicare Account Representative will transfer appropriate charges and request the bill for exact dates to avoid overlap.
4. If Medicare is added to any inpatient account, the person adding Medicare is responsible for checking for any outpatient account 72 hours prior to the inpatient admission and notifying the billing supervisor.

<b>MONITORING TOOLS</b>
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Review the 72-Hour Pathfinder Report monthly and document results on the “72 Hour Protocol Monitoring Form”.

Approved:

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Date: \_\_\_\_\_