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	<u>Subject</u> Combined Billing of Medicare Admissions	<i>Effective Date</i>	1/3/05
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POLICY/PROCEDURE

This procedure applies to the JHHS and the following entities: The Johns Hopkins Hospital (JHH), Johns Hopkins Bayview Medical Center (JHBMC), and Howard County General Hospital (HCGH).


OVERVIEW: Medicare has modified its' billing requirements effective 1/03/05. The changes relate to combined billing for discharges and readmissions on the same day for related conditions (see transmittal MM3389). When a patient is readmitted to the same hospital on the same day for symptoms related to, or for evaluation and management of, the prior stay's medical condition, hospitals will submit both stays on a single claim. In addition, Medicare will no longer recognize the '05' patient status/discharge code on the UB04 for cases where a patient is discharged from a med/surg unit and admitted to a psychiatric unit/hospital. In that circumstance, a '65' patient discharge status code must be utilized.

For JHH discharges and admissions in and out of the Oncology service, cases must also be combine billed (see bulletin MM3364 and MM3417).

On the JHBMC campus, discharges from the acute hospital to the chronic hospital should be coded using the '63' patient status/ discharge code- "to a long-term care facility."

PROCEDURES for JHBMC and HCGH (Meditech Hospitals)

1. A daily report will be produced for Medical Records, Case Management, and Medicare billing that will identify patients that are discharged and readmitted on the same day. This report will not include patients that are discharged and readmitted for psychiatric services (or visa versa). Case Management (HCGH) or Medical Records (JHBMC) will determine if the second admission is "related". Relatedness should be determined within a maximum of a 48-hour timeframe. The assigned party will notify the Medicare biller (HCGH) or Supervisor (JHBMC) of 'relatedness'.
2. JHBMC Medical Records will be responsible to copy over diagnostic coding related to the first stay on to the second stay in the Medical Records abstracting module. HCGH Medical Records will e-mail the diagnostic codes to the biller within 48 hours of the request.
3. The Medicare biller will place the initial account on bill hold pending determination from Case Management/Medical records on whether or not the cases are related. If related, the Biller will take or request the following actions:
 - Charges will need to be moved from the first admission to the second admission
 - Charges may prorate incorrectly due to the admission date on the second admission not being equal to the first admission. The covered days will be incorrect on the claim.
 - The claim will need to be modified to change the admission date or period from date to the admission date of the first admission
 - The admitting/principle diagnostic code must be used from the first admission
 - Appropriate occurrence codes and condition codes on the first admission will need to be moved and combined with the second admission
 - Monitoring of the first case will need to continue as any late charges that are posted will need to be moved subsequently to the second case for billing
 - The Biller will have to correct proration on the second account to indicate the covered days based on the combined admissions
 - If the account has cycle billed, subsequent payments/adjustments will post to the first admission and will need to be moved to the second

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- If the two cases are 'unrelated', the Biller will release the first case from the hold status and indicate a 'B4' condition code on the second case.

Note: Medicare has advised that 'B4' cases will be reviewed.


4. Case Mix management will need to determine how to track charges for the two cases via HSCRC reporting. This can be done by matching dates of service against the two abstracted records.

PROCEDURES for JHH (Keane)

The procedures outlined below addresses both the readmission on the same day of discharge as described for HCGH and JHBMC in addition to the procedures required for Oncology services at JHH.

Please note that the involvement of PIUM is for same day readmissions to help determine relatedness and not for patients transferring in and out of Oncology via our discharge procedure.

1. A daily report will be produced for Medical Records, PIUM, and Medicare billing that will identify patients that are discharged and readmitted on the same day. This report will not include patients that are discharged and readmitted for psychiatric services, rehabilitation services (or visa versa). PIUM will determine if the second admission is "related". Relatedness should be determined within a maximum of a 48-hour timeframe. The Medicare Billing Supervisor will be notified of "relatedness".
2. The biller will flag the first admission for bill hold pending the decision on relatedness. If the case is a discharge and readmission from/to the Oncology Center, the biller will "link" case one to case two. If, in fact, the patient went from Oncology to Medicine and returned to Oncology, the next day's report should indicate the second admission and third admission as requiring a link. In that case, the biller would link case two to case three. At final billing, the biller would have to make the following adjustments:
 - The Admitting diagnosis/principle diagnosis will need to be modified to agree with the coding on case one. A PMU update request to modify the admission date on case two (or case three, depending on the number of cases) would be done to pull the admission date from the first admission.
 - The biller would go into the second (or tertiary case) and modify the proration to include all days required on the Medicare admission (i.e., 60, 30, 60). If a cycle bill has occurred on the first admission, a subsequent payment should automatically transfer to the second or third case once the cases are linked.
 - Occurrence coding and condition coding from prior cases will need to be added to the third case.
 - If the second readmission is not related, the biller will need to release the first case and code the second case with a "B4" condition code.
 - Only one admission charge should be on the Oncology combined cases; others must be reversed
3. Case Mix management will produce separate HSCRC reporting logic for the cases and be able to split charges by date of service and location. In addition, logic should include replacing the admission date on the last case with the discharge date of the prior case.

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RESPONSIBILITIES

Medical Records: If Medicare requests records, Medicare will need both charts when combined billing has occurred. At JHBMC, Medical Records must move the diagnostic codes from case one to case two in order to ensure billing has all appropriate coding on the case. (This cannot be done in the BAR module.) HCGH Medical Records will e-mail the diagnostic codes to the biller.

Case Management/PIUM/Medical Records at BMC: Responsible to determine relatedness in 48 hours from the readmission.

Case Mix Management: Responsibilities include ensuring HSCRC reporting is appropriate for cases that are combined.

Billing: Responsible to hold accounts where appropriate, make corrections on claims that include the admission/principle diagnostic coding, occurrence coding, condition codes, admission charges, requesting links or charge movement, correcting proration, days covered, and the 'B4' condition code should the case be unrelated.

Customer Services: Needs to recognize that the patient's calling on these cases will be getting one bill and the bill will reflect the account number of the last case along with the application of deductibles, co-insurance, etc., all applying to the last case which would reflect all the charges for the combined admissions.

SPONSOR

Senior Director of Patient Financial Services, JHHS

REVIEW CYCLE

Three (3) years

APPROVAL

 Director, Patient Financial Services, HCGH

 Date

 Director, Third Party Billing, JHHS

 Date

 Sr. Director, Patient Financial Services, JHHS

 Date