

## January 19, 2012 Three-Day Window Rule



HFMA Northern California  
COMPLIANCE WEBINAR SERIES  
*California Statewide Webinar*

## Speaker

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## Disclaimer

- This material is designed and provided to communicate information about clinical documentation, coding, and compliance in an educational format and manner. The author is not providing or offering legal advice, but rather practical and useful information and tools to achieve compliant results in the area of clinical documentation, data quality, and coding.
- Every reasonable effort has been taken to ensure that the educational information provided is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility and clinical situation.

## Goals/Objectives

- Review & enhance your knowledge of the “three-day” window rule
- Understand the new CMS clarification/guidance
- Review and discuss some case examples
- Answer these questions ... What is your Department role? Are you in compliance?
- Action and Next steps...

## Three Day Window Rule

- The three-day payment window rule arose from the contention by HCFA (now called CMS) that when the prospective payment system for hospitals was set up in 1983, the costs related to preadmission services were included in the base year costs used to calculate the standardized payment amount and the DRG weighting factors.
- Therefore, these preadmission services (lab/radiology) could not be billed separately from the covered inpatient services that follow, since payment for them was included in the DRG payment for the inpatient stay made under Medicare Part A.

NOTE: For hospitals excluded from Medicare's prospective payment system, the applicable payment window is only one day.

## Compliance Is Important

- Compliance and revenue risk if not correctly handled
  - Inappropriate outpatient payments for preadmission services
  - Over stated inpatient outlier payments
    - Inaccurate DRGs
  - Collect incorrect patient coinsurance or deductibles
  - Under payment for outpatient preadmission services
- Services billed on an outpatient basis are separately payable (unless packaged into an APC)
- No separate payment is made for individual services billed on an inpatient claim

## 3-Day Rule Excluded Services

- Excluded Services:
- Under the three-day payment window rule, charges for services furnished by home healthcare agencies, skilled nursing facilities, and hospices under Medicare Part A do not need to be bundled with inpatient charges. Services provided by these entities under Medicare Part B, however, could still be subject to the bundling requirements.
- Ambulance services still are excluded from the bundling requirements, as they were under the interim final rules. Maintenance renal dialysis services also were excluded because HFCA states that outpatient chronic renal dialysis service is distinct from the type of hospital services that the payment window rule was designed to address.

## 3-Day Rule Definition: Related Services

- Services are related to an admission only when there is an exact match between the ICD-9-CM diagnosis code assigned for the preadmission services and the inpatient stay.
- Many experts contend that this definition is not widely known by hospitals and other entities within the healthcare industry.

### 3-Day Rule Definition: "Wholly Owned or Operated" Entities

- "In general, if a hospital has direct ownership or control over another entity's operations, then services provided by that other entity are subject to the three-day window. However, if a third organization owns or operates both the hospital and the entity, then the window provision does not apply."

### Examples of Wholly Owned or Operated

- Example: A hospital owns a physician clinic or a physician practice that performs preadmission diagnostic services for the hospital. Are these services subject to the bundling requirements?
- Policy: Yes, in part. A hospital-owned or hospital-operated physician clinic or practice is subject to the three-day payment window rule. The technical portion of preadmission diagnostic services performed by the physician clinic or practice must be included in the inpatient bill and may not be billed separately. A physician's professional service, however, is not subject to the payment window rule.

## Examples of Wholly Owned or Operated – Con't

- Example: Hospital A owns Hospital B, which in turn owns Hospital C. Does the payment window apply if preadmission services are performed at Hospital C and the patient is admitted to Hospital A?
- Policy: Yes. CMS would consider that Hospital A owns both Hospital B and Hospital C, and the payment window rule would apply.

## Examples of Wholly Owned or Operated – Con't

- Example: Corporation X owns Hospitals A and B. If Hospital A performs preadmission services and the patient is subsequently admitted as an inpatient to Hospital B, are these services subject to the payment window rule?
- Policy: No. The payment window rule does not apply to situations in which both the admitting hospital and the entity that furnishes the preadmission services are owned by a third entity. The payment window rule includes only those situations in which the entity furnishing the preadmission services is wholly owned or operated by the admitting hospital itself.

## Examples of Wholly Owned or Operated – Con't

- Example: A hospital refers its patient to an independent laboratory for preadmission testing services. The laboratory does not perform testing by arrangement with the admitting hospital. Are the laboratory services subject to the payment window rule?
- Policy: No. The payment window rule does not apply to situations in which the admitting hospital is not the sole owner or operator of the entity performing the preadmission testing.
- ALWAYS check with your compliance officer to clarify this definition if in doubt.

## Not 72-Hours... 3-Days

- 3 Calendar days, any portion of the day counts
- Patient seen in ER at 9 pm on the 14<sup>th</sup> of the month....
- 3 days or 72 hours.....changes to 4 days
- **Another Example:**
  - 11 pm Day #1 to 11 pm Day #2 = 24 hrs
  - 11 pm Day #2 to 11 pm Day #3 = 48 hrs
  - 11 pm Day #3 to 11 pm Day #4 = 72 hrs
- Note this now goes into 4 days, so beyond the 3-Day window rule... don't use 72 hrs!
  - Check your billing systems

## Diagnostic Services

- Services such as laboratory or radiology to determine if a particular disease process, injury, or illness exist. For this provision, diagnostic services are defined by the presence on the bill of the following revenue and/or Revenue and HCPCS codes:
  - 254 –Drugs incident to other diagnostic services; 255 - Drugs incident to radiology;
  - 30X - Laboratory; 31X –Laboratory pathological; 32X –Radiology diagnostic;
  - 341 - Nuclear medicine, diagnostic; 35X - CT scan; 40X –Other imaging services;
  - 46X –Pulmonary function; 48X - Cardiology, with HCPCS codes 93015, 93307,93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93543, 93544-93552, 93561, or 93562; 53X –Osteopathic services; 61X - MRI; 62X -
  - Medical/surgical supplies, incident to radiology or other diagnostic services; 73X –
  - EKG/ECG; 74X - EEG; 92X - Other diagnostic services

## CMS Definition of “Diagnostic”

| UB-04<br>REV<br>Code | Description and Related HCPCS/CPT Codes   |
|----------------------|---|
| 0254                 | Drugs incident to other diagnostic services   |
| 0255                 | Drugs incident to radiology   |
| 030X                 | Laboratory  |
| 031X                 | Laboratory pathological   |
| 032X                 | Radiology diagnostic  |
| 0341 and<br>0343     | Nuclear medicine, diagnostic; diagnostic radiopharmaceuticals   |
| 035X                 | Computed tomography (CT) scan   |
| 0371                 | Anesthesia incident to radiology  |
| 0372                 | Anesthesia incident to other diagnostic services  |
| 040X                 | Other imaging services  |
| 046X                 | Pulmonary function  |
| 0471                 | Audiology diagnostic  |
| 0481 and<br>0489     | Cardiology (cardiac catheterization lab and other cardiology services billed with CPT codes 93501, 93503, 93505, 93508,93510, 93526, 93541, 93542, 93543, 93544, 93556, 93561 or 93562) |
| 0482                 | Cardiology stress test  |
| 0483                 | Cardiology echocardiology   |
| 053X                 | Osteopathic services  |
| 061X                 | Magnetic resonance tomography (MRT)   |
| 062X                 | Medical/surgical supplies, incident to radiology or other diagnostic services   |
| 073X                 | Electrocardiogram (EKG/ECG)   |
| 074X                 | Electroencephalogram (EEG)  |
| 0918                 | Testing, behavioral health  |
| 092X                 | Other diagnostic services   |

## **Non-Diagnostic Services**

- Services such as therapies or treatments which aid in the treatment of a particular disease process, injury, or illness.

## **3-Day Rule Update July 2008**

- **July 1, 2008** • Medicare contractors now applying the rule based on the line item date of service • Changes to the revenue codes and CPT codes use to define diagnostic services.

## CMS Transmittal: February 2009

|                                       |  |
|---------------------------------------|--|
| CMS Manual System                     | Department of Health & Human Services (DHHS)   |
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| Transmittal 1429                      | Date: February 1, 2008                         |
|                                       | Change Request 5880                            |

Subject: Modification of Payment Window Edits in the Common Working File (CWF) to Look at Line Item Dates of Service (LIDOS) on Outpatient Claims

**I. SUMMARY OF CHANGES:** The payment window edits in the CWF will be modified to look at the LIDOS of the outpatient bill. Currently, CWF looks at the statement covers through date of the outpatient claim. This will allow hospitals to separate and receive reimbursement for the services prior to the payment window. This CR will also add some diagnostic revenue codes that were missing from the Internet Only Manual and modify the Cardiology revenue code related to this policy.

New / Revised Material  
Effective Date: July 1, 2008  
Implementation Date: July 7, 2008

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)  
R=REVISED, N=NEW, D=DELETED-Only One Per Row.

| R/N/D | Chapter / Section / Subsection / Title                   |
|-------|--|
| R     | 3/40.3/Outpatient Services Treated as Inpatient Services |

### III. FUNDING:

**SECTION A:** For Fiscal Intermediaries and Carriers:  
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

**SECTION B:** For Medicare Administrative Contractors (MACs):  
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions.

## New Attention to 3-Day Window

- "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010"
- Clarification regarding changes to the three-day payment window, as mandated by Congress on June 25, 2010.

## 3-Day Rule June 2010 Update

- The new expectations for outpatient services provided within three days prior to and including the day of inpatient admission will **leave hospital staff to determine whether therapeutic services are clinically associated with the inpatient admission.**
- The hospital must then be prepared to defend their rationale.
- Hospitals need to create a process for coders and clinical staff to work together to determine whether the outpatient services were clinically associated with the inpatient stay.
- While a greater number of claims will be combined based on this new definition, automatic bundling of all inpatient and outpatient claims will almost certainly lead to unintended loss of reimbursement.

## 3-Day Rule August 2010 Update

- Medicare's 3-Day/1-Day Payment Window Policy: Outpatient Services Treated as Inpatient
- During the Hospital Open Door Forum call on August 26th, 2010, hospitals expressed concerns regarding billing for procedures performed in the outpatient setting that must be bundled on the inpatient hospital bill in order to comply with the 3-day (or 1-day) payment window policy.
- CMS recently issued a memorandum to providers regarding a statutory change in the policy pertaining to admission-related outpatient non-diagnostic services.

## 3-Day Rule Sept Update

- 9/10/2010
- CMS has verified that the Medicare claims processing system does allow the ICD-9-CM procedure code dates for non-diagnostic services provided up to 3 calendar days prior to the admission date on the inpatient claim. Therefore, hospitals are able to bill correctly for admission-related outpatient non-diagnostic services (that is, bundle the services on the inpatient hospital claim) without modifying dates on the inpatient claim.
- The CMS foresees no system issues that prevent hospitals from billing appropriately according to the 3-day (or 1-day) payment window policy. If providers encounter systems difficulties, they should contact their local contractor, CMS Regional Office, or CMS Central Office, accordingly.

2011

## FY11 IPPS Final Rule

- **Hospitals continue to wait for final claims processing instructions to clarify how the unrelated outpatient charges are to be submitted. According to the FY11 final rule, this may be in the form of a condition code or outpatient modifier.**
- In summary, the new three-day payment window proposed provision requires that:
  - Outpatient services provided on the day of admission are included in the inpatient MS-DRG claim;
  - Outpatient diagnostic services provided within the three-day payment window are included in the inpatient MS-DRG claim;
  - Outpatient therapeutic services provided within the three-day payment window are included in the inpatient MS-DRG claim **UNLESS** the hospital attests that the services were not clinically associated with the inpatient admission. CMS has rescinded the previous definition of related services being those with an exact ICD-9-CM diagnosis code match.

## Unclear ... on Non-Diagnostic and Related

- Keep in mind that CMS will be providing additional guidance on how providers are to determine “Non-diagnostic and Related”. It appears using ICD-9-CM codes is not the answer.

## New Modifier PD

- 2012 Medicare Physician Fee Schedule
- Compliance Extension to July 2012
- As of July 1, 2012 the payment window will apply to both diagnostic *and* non-diagnostic services.
- New HCPCS Level II modifier PD *Diagnostic or related non-diagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within 3 days, or 1 day* should be appended to identify claims for related services provided within 3 days of an inpatient admission

## Modifier PD (con't)

- Medicare will pay a reduced fee for physicians' services that are **clinically related** to an inpatient admission, occur within 3 days of the admission, and are furnished by a physician practice wholly owned or wholly operated by a hospital. The rule applies whether the inpatient and outpatient diagnoses codes are the same *or different*.
- If non-diagnostic services are *not* clinically related to an inpatient admission within 3 days of admission, the hospital or wholly owned or wholly operated physician practice should document the reason those services are not clinically related. In such a case, the facility or provider should receive full payment.

## Compliance Check

- CMS considers a freestanding clinic to be a wholly owned and operated entity if the hospital has “exclusive responsibility for conducting and overseeing the entity’s routine operations.”
- When this is the case, the freestanding clinic is subject to the three-day payment window and CMS will bundle the technical component of the services provided at that clinic into the inpatient claim.

## Case Example #1

- Outpatient surgery was performed 2 days prior to the admit. Patient had an unplanned event from the surgery that led to the inpatient admit.
- The provider does not provide a complete 5th digit match (different principal dx) so therefore, all therapeutic services should be billed separately for the outpt surgery.
- Also, any codes related to the surgery should NOT be included in the DRG calculation. Even if the hospital chose not to bill the separate outpatient claim and get the surgical APC payment, the inpt DRG cannot use the surgical codes to determine the DRG. If it was, there is an audit vulnerability.
  - RAC exposure.

## Case Example #2

- A patient is seen in the hospital outpatient surgery department for planned surgical repair of a unilateral inguinal hernia. The surgery was successfully performed and the patient recovers in the hospital's observation unit. During this recovery period, the patient has an acute myocardial infarction (AMI) of the anterior wall and is admitted as an inpatient to the same hospital for 5 days.
- What is the principal diagnosis for the inpatient admission?
- **Answer:**
- Assign code 410.11, acute myocardial infarction of other anterior wall, initial episode of care, as the principal diagnosis. In this case, the patient had a documented condition, the AMI, which led to the inpatient admission. Therefore, the AMI would be the principal diagnosis.
- Code 550.91, inguinal hernia without mention of obstruction or gangrene, unilateral or unspecified (not specified as recurrent), should be assigned as an additional diagnosis.
- Assign code 53.00, unilateral repair of inguinal hernia, not otherwise specified, for the procedure performed.
- Combine the medical records per AHA Coding Clinic guidelines.

## Case Example #3

- A patient had an outpatient laparoscopic cholecystectomy 2 days ago. The patient began having difficulty breathing, was seen by their physician and was admitted with an acute exacerbation of chronic obstructive pulmonary disease (COPD).

**INCORRECT:** Combine the cholecystectomy with the inpatient encounter:  
DRG 988, DRG weight

- 1.8792 (using \$5,000 DRG rate) = \$9,396

**CORRECT:** Bill the cholecystectomy as an outpatient and the COPD exacerbation as an inpatient:

- DRG 192, DRG weight .7254 (using \$5,000
- DRG rate) = \$3,627
- APC 131 = \$3,060
- Total payment = \$6,687
- The hospital would have been overpaid \$2,709 by combining the two accounts and billing all of the services on the inpatient bill, but this isn't always the case.
- Separate medical record encounters.

## What is your Department Role?

- Health Information Management (HIM)
- Patient Financial Services (PFS – Billing)
  - Claims adjudication
- First ... conduct an audit on patients with a 3 day LOS or less
  - Use data mining
  - Do not combine the outpatient encounters unless it's a true ER admit
  - Combining the billing portions for the claim is ok
- Meet with your billing or business office leadership.

## Medical Record Review

- Pull a sample of claims and medical records that were combined due to the 3-Day Payment Window.
- Determine if the principal diagnosis on the outpatient record and the inpatient record were identical.
- If identical, determine if all services were combined to the inpatient account
- If not identical, determine if the diagnostic services were combined to the inpatient account (use diagnostic services section on page 2 to determine which revenue codes and charges should be combined) and if the therapeutic services were billed separately on an outpatient claim.

## OPPS FY12 Update

- **Transmittal 2376**
- **Payment Window for Outpatient Services Treated as Inpatient Services**
- CMS is revising its billing instructions to clarify that in situations where there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services (i.e., services provided to a beneficiary on the date of an inpatient admission or during the 3 calendar days (or 1 calendar day for a non-IPPS hospital) prior to the date of an inpatient admission) must be bundled. Therefore services provided to the beneficiary prior to the point of admission (i.e., the admission order) may be separately billed to Part B as the outpatient services that they were. See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 10.12 and chapter 1, section 50.3.2 for the updated billing guidelines.

|                                       |   |
|---------------------------------------|---|
| CMS Manual System                     | Department of Health & Human Services (DHHS)  |
| Pub 100-04 Medicare Claims Processing | Center for Medicare & Medicaid Services (CMS) |
| Transmittal 2376                      | Date: December 29, 2011                       |
|                                       | Change Request: N/A                           |

**SUBJECT:** January 2012 Update of the Hospital Outpatient Prospective Payment System (OPPS)

**I. SUMMARY OF CHANGES:** This Revenue Update Notification describes changes to and being submitted to various policies implemented in the January 2012 OPPS update. 9 affects Chapter 1, Section 10.12, Chapter 5, Section 50.3.2, and Chapter 11, Section 10.1.1. CMS is updating information in this notice.

The January 2012 Inpatient Outpatient Code Editor (OCE) and OPPS Show will reflect the Medicare Coverage Pronunciation Coding Update (MPCU), Ambulatory Payment Classification (APC), HCPCS Modifiers, and Revenue Code Addition, Change, and Deletion identified in this Change Request (CR).

**EFFECTIVE DATE:** January 1, 2012  
**IMPLEMENTATION DATE:** January 1, 2012

*Disclaimer for manual changes only: The revenue code and payment number (R13) are not included in this notice. All other manual changes published and provided unchanged. Before, if the revenue code is not of interest, you will receive the same information only, and you do not have to take any action.*

**II. CHANGES IN MANUAL INTERCTIONS:** (If A, it is not updated)  
**POSITIONS IDENTIFIED:**

| BOOK | CHAPTER | SECTION | DESCRIPTION  | TITLE |
|------|---------|---------|--|-------|
| R    | 10      | 10.12   | Policy and Billing Instructions for Condition Code 44                |       |
| R    |         |         | Table of Contents  |       |
| R    | 10      | 10.12   | Condition Code Identification Changes                                |       |
| R    | 10      | 10.12   | Payment Window for Outpatient Services Treated as Inpatient Services |       |
| R    | 10      | 20.4    | Use of Modifier for Discontinued Services                            |       |

## OPPS FY12 Update

- **10.12 – Payment Window for Outpatient Services Treated as Inpatient Services (Rev. 2376, Issued: 12-29-11, Effective: 01-01-12, Implementation: 01-03-12)**
- Outpatient non-diagnostic services that are related to an inpatient admission must be bundled with the billing for the inpatient stay. An outpatient service is related to the admission if it is **clinically associated with the reason for a patient's inpatient admission**.
- In accordance with section 102 of Pub. L. 111-192, for services furnished on or after June 25, 2010, all outpatient non-diagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission, and thus, must be billed with the inpatient stay.
- A hospital may attest to specific non-diagnostic services as being unrelated to the hospital claim (that is, the preadmission non-diagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a **condition code 51 (definition "51 - Attestation of Unrelated Outpatient Non-diagnostic Services")** to the separately billed outpatient non-diagnostic services claim.
- Providers may submit outpatient claims with condition code 51 starting April 1, 2011, for outpatient claims that have a date of service on or after June 25, 2010. Outpatient claims with a date of service on or after June 25, 2010, that did not contain condition code 51 received prior to April, 1, 2011, will need to be adjusted by the provider if they were rejected by FISS or CWF.

## Next Steps . . .

- **Form a 3-Day Rule Team**
  - This may include:
    - Finance                      Registration
    - Health Information Management
    - Billing                              IT
    - Legal
  - Duties may include: Addressing system implications, regular communications and developing education
    - Obtain a list of denials that may be related to the 3-day rule
      - Check the RAs and the Common Working File

## Next Steps . . .

- **Review the claims for the following high-risk areas:**
  - Claims with multiple bill type changes.
  - Patterns in the type of claims (e.g., labs, cardiac rehab, physical therapy).
  - Too many edits, or too few.

## Next Steps . . .

- **Verify the proper assignment of the date of service for testing, therapies, and interventions.** Identify how the system assigns a date of service for hospital services
- **Prepare an in-service.** Include billing staff working with these claims, registrars, and clinical staff who provide these services. Teach them how to properly check for repetitive service accounts and how to properly place and screen for changes

## Next Steps . . .

- Watch for additional guidance from CMS
- Key Points
  - WHO
  - WHEN
  - WHAT

## Compliance!

- REMEMBER: 72 hours does not necessarily equal three (3) days.
- Check on outpatient practices that are wholly owned

## Summary

- Outpatient diagnostic services provided within three (3) days of the admission, or ii) non-diagnostic or therapeutic outpatient services provided within three (3) days of the admission and "related" to the inpatient admission are combined into the inpatient claim.
- Currently "Related" services are defined as those in which the diagnosis of the outpatient visit and the principal diagnosis of the inpatient admission are an exact match to the fifth digit level of the ICD-9-CM diagnosis codes.

## Summary: Understand the three-day rule

- The three-day rule bundles certain outpatient preadmission services into the inpatient Medicare Severity diagnosis related group (MS-DRG) payment. This means they are billed as part of the inpatient claim, and payment is made as part of the applicable DRG for the case.
- These three factors should help coders determine whether an outpatient service is subject to the three-day rule:
  - The relationship of the inpatient and outpatient providers
  - The nature of the service
  - The date the outpatient service is rendered

## Summary

- The three-day rule applies to the day of admission as well as the three calendar days prior to admission.
- Not “72 hr” although often referred to as this.
- Understand the use Modifier PD

## Summary

- For Non-Prospective Payment System (Non-PPS) Facilities/Units: i) outpatient diagnostic services provided within one (1) day of the admission, or ii) nondiagnostic or therapeutic outpatient services provided within one (1) day of the admission and "related" to the inpatient admission.
- Related services are defined as those in which the principal diagnosis of the outpatient visit and the principal diagnosis of the inpatient admission are an exact match to the fifth digit level of the ICD-9-CM diagnosis codes.

## Summary

- Services furnished on the day of admission, particularly ED visits may have Revenue opportunity!
- Review the OPPS Update transmittal
- Discuss with your Compliance Officer and Business Office leadership.

## Questions . . . ?

Northern California HFMA Spring Conference  
Sheraton Grand, Sacramento  
March 21-22, 2012  
[www.hfma-nca.org](http://www.hfma-nca.org)

Keynotes:

*Greg Adams, HFMA Board of Directors National  
Chair*

*Executive Panel comprised of Michael D. Blaszyk  
(CHW), Jerry Fleming (Kaiser Permanente), and  
Kristen Miranda (Blue Shield)*

*32 breakout sessions including a new Technology  
track & “Enhancing Your Skills” intermediate  
healthcare finance education*

Thank you

## References/Resources

- **Compliance Today, “Three-day Payment Window Rule”, December 2009**
- <http://www.cms.gov/manuals/downloads/clm104c03.pdf>
- <http://blogs.hcpro.com/medicarefind>
- RAC Monitor
- **Healthcare Financial Management, May, 1998 by Richard L. Gundling**
- <http://www.cms.gov/AcuteInpatientPPS/Downloads/JSMTDL-10382%20ATTACHMENT.pdf>
- <  
<http://www.cms.gov/AcuteInpatientPPS/Downloads/JSMTDL-10382%20ATTACHMENT.pdf>>
- **Demystify Medicare’s Three-Day Payment Window: Understand the Rule and Maintain Best Practices, Hcpro, July 2008**

## Speaker Bio

- Gloryanne is the HIM Managing Director in Revenue Cycle, N. California, Kaiser Foundation and Hospitals. She is a RHIA (Registered Health Information Administrator), a RHIT (Registered Health Information Technician), Certified Coding Specialist (CCS), a Certified Clinical Documentation Specialist (CCDS) and a Certified ICD-10 Trainer with over 30 years of experience in the health information management (HIM) profession.
- Ms. Bryant has conducted numerous ICD-9-CM, ICD-10 and CPT coding, DRGs, MS-DRG, APR-DRGs and APC (OPPS) workshops for hospital based coders and others. In addition she has made an array of presentations on data quality, medical necessity, compliance and clinical documentation improvement to management executives and healthcare administrators.
- She received the AHIMA Triumph Award in the category of HIM "Champion" in the fall of 2007. Gloryanne is a sought-after national speaker and author on healthcare compliance, reimbursement, clinical documentation improvement, coding regulations (ICD-9-CM, ICD-10 and CPT) and serves as a catalyst for change and improvement in HIM and healthcare.