DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

News Flash – On November 17, 2011, the Centers for Medicare & Medicaid Services' Office of E-Health Standards and Services (OESS) announced that it would not initiate enforcement with respect to any Health Insurance Portability and Accountability Act (HIPAA) covered entity that is not in compliance on January 1, 2012, with the ASC X12 Version 5010 (Version 5010), National Council for Prescription Drug Programs (NCPDP) Telecom D.0 (NCPDP D.0) and NCPDP Medicaid Subrogation 3.0 (NCPDP 3.0) standards until March 31, 2012. Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for use of these new standards remains January 1, 2012. (Small health plans have until January 1, 2013, to comply with NCPDP 3.0.)

MLN Matters® Number: MM7502

Related Change Request (CR) #: 7502

Related CR Release Date: December 21, 2011

Effective Date: January 1, 2012

Related CR Transmittal #: R2373CP

Implementation Date: January 3, 2012

Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window Policy and the Impact on Wholly Owned or Wholly Operated Physician Offices

Provider Types Affected

This article is for physicians, providers, and suppliers submitting claims to Medicare contractors (carriers, Fiscal Intermediaries (FIs) and/or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

Physicians, suppliers, and providers must insure that their billing staffs are aware of these new changes to the rules for services provided to outpatients who are later admitted as inpatient. The Centers for Medicare & Medicaid services (CMS) includes these changes in CR7502.

Background

On June 25, 2010, the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) (Pub. L. 111-192) was enacted. Section 102 of this Act entitled, "Clarification of 3-Day Payment Window," clarified when certain nondiagnostic services furnished to Medicare beneficiaries in the 3-days (or, in the case of a hospital that is not a Subsection (d) hospital, (e.g. psychiatric, inpatient rehabilitation, or long-term care) during the 1 day) preceding an inpatient admission should be considered “operating costs of inpatient hospital services” and therefore included in the hospital’s payment under the Hospital Inpatient Prospective Payment System (IPPS). This policy is generally known as the "3-day payment window."

Under the 3-day payment window, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the inpatient claim for a Medicare beneficiary’s inpatient stay, the technical portion of all outpatient diagnostic services and admission-related nondiagnostic services provided during the payment window. The statute makes no changes to the existing policy regarding billing of diagnostic services.

Prior to June 25, 2010, and the enactment of Public Law 111–192, the payment window policy for preadmission nondiagnostic services was rarely applied as the policy required an exact match between the principal ICD–9 CM diagnosis codes for the outpatient services and the inpatient admission. The requirement of the exact match resulted in very few services furnished in an entity that is wholly owned or operated by the hospital being subject to the policy. The statutory change to the payment window policy made by Public Law 111–192 significantly broadens the definition of nondiagnostic services that are subject to the payment window to include any nondiagnostic service that is clinically related to the reason for a patient’s inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same.

In accordance with Section 102(a)(1) of the PACMBPRA, for outpatient services furnished on or after June 25, 2010, the technical portion of all nondiagnostic 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, therefore, must be included on the bill for the inpatient stay. Also, the technical portion of outpatient nondiagnostic 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 first, second, and the third calendar days (1 calendar day for a nonsubsection (d) hospital) immediately preceding the date of admission are deemed related to the admission and, therefore, must be billed with the inpatient stay.

PACMBPRA did not change the requirement that the technical portion of all diagnostic services provided by the hospital (or entity wholly owned or wholly operated by the hospital) occurring on the date of an inpatient admission, or during the 3 calendar days (or 1 calendar day) immediately preceding the date of an inpatient admission must be billed with the inpatient admission.

NOTE: If the nondiagnostic services are unrelated to the inpatient hospital claims, that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's inpatient admission, the unrelated outpatient hospital nondiagnostic services are covered by Medicare Part B, and the wholly owned or wholly operated entity shall include the technical portion of the services in their billing.

Implementation of the 3-day Payment Window Policy in Wholly Owned or Wholly Operated Entities

Wholly owned or wholly operated entities are subject to the 3-day (or 1-day) payment window policy when they furnish preadmission diagnostic services to a patient who is later admitted as an inpatient on the same day or within the preceding 3 calendar days (preceding 1 calendar day), or when they furnish preadmission nondiagnostic services to a patient, who is later admitted as an inpatient on the same day or within the preceding 3 calendar days (preceding 1 calendar day) for related medical care.

When an entity that is wholly owned or wholly operated by a hospital furnishes a service subject to the 3-day window policy, Medicare will pay the professional component of services with payment rates that include a professional and technical split and at the facility rate for services that do not have a professional and technical split. Once the entity has received confirmation of a beneficiary's inpatient admission from the admitting hospital, they shall, for services furnished during the 3-day window, append a CMS payment modifier to all claim lines for diagnostic services and for those nondiagnostic services that have been identified as related to the inpatient stay. Physician nondiagnostic services that are unrelated to the hospital admission are not subject to the payment window and shall be billed without the payment modifier.

Defining Wholly Owned and Wholly Operated Entities

Wholly owned or wholly operated entities are defined in 42 CFR §412.2: "An entity is wholly owned by the hospital if the hospital is the sole owner of the entity." And, "an entity is wholly operated by a hospital if the hospital has exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity."

Payment Methodology

CMS has established new payment modifier PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days), and require that the modifier be appended to

the entity's preadmission diagnostic and admission-related nondiagnostic services, reported with HCPCS/CPT codes, which are subject to the 3-day payment window policy. The wholly owned or wholly operated entity will need to manage their billing processes to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. The hospital is responsible for notifying the entity of an inpatient admission for a patient who received services in a wholly owned or wholly operated entity within the 3-day (or, when appropriate, 1-day) payment window prior to the inpatient stay.

The modifier is available for claims with dates of service on or after January 1, 2012, and entities may begin to coordinate their billing practices and claims processing procedures with their hospitals to ensure compliance with the 3-day payment window policy no later than for claims received on or after July 1, 2012.

When the modifier is present on claims for service CMS shall pay:

- Only the Professional Component (PC) for CPT/HCPCS codes with a Technical Component (TC)/PC split that are provided in the 3- calendar day (or, 1- calendar day) payment window; and
- The facility rate for codes without a TC/PC split.

Global Surgical Services and the 3-day Payment Window Policy

We note that the time frames associated with 10 and 90 day global surgical packages could overlap with the 3-day (or 1-day) payment window policy. The 3-day payment window makes no change in billing surgical services according to global surgical rules, and pre- and post-operative services continue to be included in the payment for the surgery. However, there may be times when the surgery itself is subject to the three-day window policy, as would occur if the surgery were performed within the three-day window. For example, a patient could have a minor surgery in a wholly owned or wholly operated entity and then, due to a complication, be admitted as an inpatient. In such cases the modifier shall be appended to the appropriate surgical HCPCS/CPT code.

Additional Information

The official instruction, CR7502 issued to your carrier, FI or A/B MAC regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2373CP.pdf on the CMS website. Revised portions of the "Medicare Claims Processing Manual," containing further details on this change, are attached to CR7502.

If you have any questions, please contact your carrier, FI or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip on the CMS website.