CMS 3-Day Payment Window for Wholly Owned or Wholly Operated Physician Practices
By: Mary Cronin, Director

If you have a wholly owned or wholly operated physician practice, you need to be aware of the new Medicare three-day payment window which was published in the Federal Register (Volume 76 No. 228) on November 28, 2011 as a part of the “Medicare Program; Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition and Other Revisions to Part B for CY2012” final rule.

Per the Federal Register: “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 claim for a Medicare beneficiary’s inpatient stay, the technical portion of any outpatient diagnostic service and non-diagnostic services related to the admission provided during the payment window. The new law makes the policy pertaining to admission-related non-diagnostic services more consistent with common hospital billing practices.”

The payment window is only 1-day for non-subsection (d) hospitals (which is a hospital not paid under the Inpatient Prospective Payment System - psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children’s hospitals and cancer hospitals).

Per 42 CFR 412.2(c)(5)(i) - “An entity is wholly owned by the hospital if the hospital is the sole owner of the entity. 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”.

The 3-day payment window policy applies to services related to the admission including all diagnostic services and clinically related non-diagnostic services, other than ambulance and maintenance renal dialysis services, which would be paid for under Medicare Part B and that are provided by a hospital (or an entity wholly owned or operated by the hospital) to a patient. This is not limited to physician offices or clinics; it
includes any Part B entities that provide diagnostic or related non-diagnostic services which would include a variety of entities such as clinical laboratory facilities, ambulatory surgical centers, and diagnostic centers.

Wholly owned or wholly operated entities which provide diagnostic services have always been subject to the payment window. This final rule is to encourage hospitals to bring any other wholly owned or wholly operated Part B entities into compliance with the 3-day payment window policy. Rural Health Clinics and Federally Qualified Health Centers are not currently included under the 3-day payment window since they are reimbursed through an all-inclusive rate.

For services provided within the 3-day payment window the wholly owned or wholly operated entities will be reimbursed the professional component for CPT/HCPCS codes with a Technical Component (TC)/Professional Component (PC) split. For codes without the TC/PC split the facility rate will be paid to avoid duplicate payment for the technical resources involved.

The three-day payment window does not make any changes to the billing of surgical services under the global surgical rules. Although if the surgery were performed within the three-day payment window then the surgery itself may be subject to the three-day window.

The hospital is responsible for notifying the practice of related inpatient admissions for a patient who received services in a wholly owned or wholly operated entity within the 3-day window prior to an inpatient stay.

Beginning on January 1, 2012 CMS payment 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 the 3 days, or 1 day) is available and wholly owned or wholly operated entities should begin to append the modifier to claims as appropriate. The modifier is not required until July 1, 2012 but CMS encourages hospitals and their wholly owned or wholly operated entities to work toward establishing the necessary internal processes to ensure compliance by the deadline.

The charges related to the technical component of all outpatient diagnostic services and admission related non-diagnostic services provided within the 3-day payment window must be included on the inpatient claim.

A hospital must also include the cost related to the technical component of all diagnostic and admission related non-diagnostic services furnished by wholly owned or wholly operated entities in the 3-day payment window on their cost report.
The final rule contains a number of examples regarding under what type of arrangement the 3-day payment window applies based on various relationship structures.

Since providers are required to start applying the PD modifier to their claims by July 1, 2012 this is an issue that needs to be addressed immediately. For many providers this will not be an easy process since the wholly owned or wholly operated entities are often on different information systems than the hospital.

As hospitals and physician groups continue to align, affiliate and otherwise comingle business relationships, each should be aware of the billing requirements and how it could affect their practice. Documentation of the business relationship, including policies and procedures should include a position on the billing practices is warranted. In addition, as providers are ramping up efforts to acquire physician practices, careful consideration of the effect of this reimbursement mechanism should be considered during the strategic planning and negotiating process.

*If you would like more information on the 3-day payment window and how it might affect your facility or affiliation, please contact Mary Cronin at mcronin@besler.com or 732-839-1217.*