

Frequently Asked Questions CR 7502 (Bundling of Payments for Services Provided to Outpatients Who Later Are Admitted as Inpatients: 3-Day Payment Window and the Impacts on Wholly Owned or Wholly Operated Physician Offices)

In the calendar year (CY) 2012 Medicare Physician Fee Schedule (MPFS) final rule, published November 28, 2011, CMS finalized the 3-day payment window policy's application to physician fee schedule services consistent with section 102 of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) (Pub. L. 111-192). The implementing manual instructions (as contained in CR 7502) were published on December 21, 2011. A compilation of frequently asked questions (FAQs) about CR 7502 and the CMS response(s) are provided below.

Q.1. What is the 3-day payment window?

A.1. Medicare's 3-day (or 1-day) payment window applies to outpatient services furnished by hospitals and hospitals' wholly owned or wholly operated Part B entities. The statute requires that hospitals' bundle the technical component of all outpatient diagnostic services and related non-diagnostic services (e.g. therapeutic) with the claim for an inpatient stay when services are furnished to a Medicare beneficiary in the 3 days (or, in the case of a hospital that is not a subsection (d) hospital, during the 1-day) preceding an inpatient admission in compliance with §1886 of the Social Security Act.

Q.2. How does section 102 of the (PACMBPRA) change the way that a physicians practice, or any other Part B entity, that is wholly owned or wholly operated by a hospital, bill and receive payment for Medicare services subject to the 3-day payment window?

A.2. Section 102 of PACMBPRA significantly broadened the definition of related non-diagnostic services that are subject to the payment window to include any non-diagnostic 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. PACMBPRA made no changes to application of the 3-day (or 1-day) payment window policy to diagnostic services. Application of the payment window policy to diagnostic services is unchanged since 1998.

Q.3. Which services are considered diagnostic services?

A.3 As discussed in the Medicare Benefit Policy Manual (Publication 100-02, chapter 6, section 20.4.1) a service is "diagnostic" if it is an examination or procedure to which the patient is subjected, or which is performed on materials derived from a hospital outpatient, to obtain information to aid in the assessment of a medical condition or the identification of

a disease. Among these examinations and tests are **diagnostic laboratory services such as hematology and chemistry, diagnostic x-rays, isotope studies, EKGs, pulmonary function studies, thyroid function tests, psychological tests, and other tests** given to determine the nature and severity of an ailment or injury.

Q.4. What type of hospital inpatient admissions would be subject to a 1-day payment window?

A.4. The hospital and hospital units subject to the 1-day payment window policy (instead of the 3-day payment window) are psychiatric hospitals and units, inpatient rehabilitation hospitals and units, long-term care hospitals, children's hospitals and cancer hospitals. A wholly owned or wholly operated physician practice (or other Part B entity) of the aforementioned hospitals would also be subject to a 1-day payment window when furnishing diagnostic services and related non-diagnostic services within 1 calendar day preceding an inpatient admission.

Q.5. Are Critical Access Hospitals (CAHs) subject to the payment window?

A.5. If the admitting hospital is a CAH, the payment window policy does not apply. However, if the admitting hospital is a short stay acute hospital paid under the inpatient prospective payment system (IPPS) hospital and the wholly owned or wholly operated outpatient entity is a CAH, the outpatient CAH services are subject to the payment window. The CAH services are also subject to the payment window if the admitting hospital is a psychiatric hospital, inpatient rehabilitation hospital, long-term care hospital, children's hospital, or cancer hospital.

Q.6. Does the 3-day window (or 1-day window) include the 72 hours (or 24 hours) directly preceding the inpatient hospital admission?

A.6. The 3-day payment window applies to services provided on the date of admission and the 3 calendar days preceding the date of admission that will include the 72 hour time period that immediately precedes the time of admission but may be a longer than 72 hours because it is a calendar day policy. The 1-day payment window applies to the date of admission and the entire calendar day preceding the date of admission and will include the 24 hour period that immediately preceded the time of admission but may be longer than 24 hours.

Q.7. What type of information about Medicare's 3-day (or 1 day) payment window was published in CR 7502?

A.7. CR 7502 provides implementing policy, billing, and claims processing instructions regarding Medicare's 3-day (or 1-day) payment window policy as it pertains to services furnished by hospital wholly owned or wholly operated physician practices or other Part B entities. These instructions include general background information on the payment

window, implementation of the payment window policy in wholly owned or wholly operated entities, **the definition of wholly owned and wholly operated entities**, and how the payment window affects payment to wholly owned and wholly operated entities. CR 7502 also includes instructions regarding how services subject to the 3-day (or 1-day) payment window should be identified, how the payment window policy affects payment and billing for surgical services with a global period as well as business requirements for Medicare claims processing contractors. Although CR 7502 includes comprehensive and detailed explanation of the 3-day (or 1-day) payment window policy, much of the information (i.e. definition of a wholly owned or wholly operated hospital and application of the policy to diagnostic services) is unchanged since 1998 and has been long-standing Medicare payment policy.

Q.8. Does CR 7502 furnish any specific billing instructions for hospitals?

A.8. No, CR 7502 only provides billing instructions for the wholly owned or wholly operated physician practice or other Part B entity when furnishing services subject to the 3-day (or 1-day) payment window. Hospital instructions for the implementation of this provision may be found in CR 7142, Transmittal 796, published October 29, 2010 entitled “Clarification of Payment Window for Outpatient Services treated as Inpatient Services.”

Q.9. How do I know if my physician practice, or other Part B entity, meets the statutory requirements of hospital wholly owned or hospital wholly operated?

A.9. 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 entities routine operations, regardless of whether the hospital also has policy making authority over the entity.” [Emphasis added] The hospital and associated physician practice or other Part B entity must determine whether the entity is wholly owned or wholly operated.

Q.10. When would the 3-day (or 1-day) payment window not apply?

A.10. The 3-day (or 1 day) payment window does not apply in the circumstances described below:

- **If the hospital and the physician office or other Part B entity are both owned by a third party, such as a health system; and**
- **If the hospital is not the sole or 100 percent owner of the entity, for example, if the hospital has a financial or administrative partner, or if physicians or other practitioners have an ownership interest in the hospital, physician practice or Part B entity. We provide several examples of arrangements where an entity is not wholly owned or wholly operated by the hospital. See the February 11, 1998 *Federal***

Register, pages 6866-6867 and the CY 2012 Medicare physician fee schedule final rule, published November 28, 2012, pages 73285 -73286).

Q.11. Will CMS make a determination as to whether a specific entity meets the definition of wholly owned or wholly operated?

A.11. Given the multitude of possible business and financial arrangements that may exist between a hospital and a physician practice or other Part B entity, CMS will not make individual determinations as to whether a specific physician practice or other Part B entity is wholly owned or wholly operated by an admitting hospital.

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 payment window policy. However, if a third organization owns or operates both the hospital and the entity, then the payment window provision does not apply. While CMS cannot anticipate every arrangement scenario or make case by case decisions based upon hypothetical scenarios, we have provided several illustrative examples of how this general policy is applied in the CY 2012 Medicare physician fee schedule final rule, published November 28, 2012 (76 FR 73285 -73286).

Q.12. Who makes the determination as to whether a specific entity meets (or does not meet) the definition of wholly owned or wholly operated?

A.12. The hospital and its owned or operated physician practice (or other Part B entity) are collectively responsible for determining whether the owned or operated physician practice or other Part B entity meets the definition of hospital wholly owned or hospital wholly operated subject to the payment window policy.

Q.13. If my physician practice has recently been purchased by a hospital should I update my ownership status with Medicare?

A.13. Yes, you must notify Medicare of any change of ownership within 30 days of the change. This notification can be done through the submission of an 855B Medicare Enrollment Application to your Medicare Administrative Contractor or you can complete this information on-line in the Provider Enrollment Chain and Ownership System.

Q.14. What if the determination of wholly owned or wholly operated of a specific arrangement is still unclear (after review by an entity's legal counsel)?

A.14. CMS believes that ownership and operational issues are inherently fact specific and hospitals and hospital owned and operated entities will know and understand best their individual circumstances and whether the physician practice is subject to the payment window policy. If an entity determines that it is not wholly owned or wholly operated and

not subject to the payment window policy, we recommend that it maintain documentation to support that determination.

Q.15. How will a wholly owned or wholly operated entity know when a beneficiary has been admitted as a hospital inpatient?

A.15. The admitting hospital is responsible for notifying the entity of an inpatient admission of a Medicare beneficiary who received services in a wholly owned or wholly operated entity within the 3-day (or 1-day) payment window prior to the inpatient admission.

Q.16. Do the ICD-9 diagnosis codes for the inpatient admission and outpatient non-diagnostic service need to be an exact match to be considered related?

A.16. No. That is the exact policy that was changed by PACMBRA. Prior to the enactment of PACMBRA, related non-diagnostic services were those services where there was an exact match on the ICD-9 diagnosis code between pre-hospitalization services and the inpatient admission. The only change that PACMBRA made was to expand the definition of ‘related to’ services to “all services that are not diagnostic services unless the hospital demonstrates...that such services are not related...to such admission. The 3-day payment policy now applies to all non-diagnostic services provided during the payment window unless the hospital attests that the services are clinically unrelated. Diagnostic services always are subject to the payment window, irrespective of whether they are considered clinically related.

Q.17. Will CMS furnish a list of non-diagnostic service codes that will be considered “related to” an inpatient admission?

A.17. CMS will not develop a definitive list of services that are clinically related to an inpatient admission. As discussed in the CY 2012 MPFS final rule, CMS believes that the determination of whether an outpatient service is clinically related requires knowledge of the specific clinical circumstances surrounding a patient’s inpatient admission and can only be determined on a case by case basis (76 FR 73282).

Q.18. Who is responsible for making the determination as to whether a non-diagnostic service is (or is not) clinically related to the beneficiary’s inpatient admission?

A.18. The hospital that owns the wholly owned or wholly operated physician practice (or other Part B entity) and submits the claim to Medicare for the inpatient admission determines that an outpatient service is clinically related to an inpatient admission when it submits an inpatient claim. Once the hospital makes this determination, the Part B claim for physician fee schedule services must be submitted consistent with the decision made by the hospital.

Q.19. How does the 3-day payment window affect wholly owned or wholly operated physician practices (or other Part B entities)?

A.19. The technical component for all diagnostic services and those direct expenses that otherwise would be paid through non-facility practice expense relative value units for non-diagnostic services related to the inpatient admission, provided by a wholly owned or wholly operated entity within the payment window, are considered hospital costs and must be included on the hospital's bill for the inpatient stay. Medicare will pay the wholly owned or wholly operated entity through the Physician Fee Schedule for the professional component (PC) for service codes with a Technical/Professional Component (TC/PC) split that are provided within the payment window, and at the facility rate (i.e. exclusive of those direct practice expenses that are included in the hospital's charges) for service codes without a TC/PC split.

Q.20. How will a wholly owned or wholly operated physician practice or other Part B entity identify services subject to the 3-day (or 1-day) payment window?

A.20. Physician practices or other Part B entities should use 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 or 1 day) to identify HCPCS codes for services subject to the payment window.

Q.21. When is the effective date for the modifier PD?

A.21. Wholly owned or wholly operated entities have the discretion to apply the modifier PD for claims with dates of service on and after January 1, 2012, but must begin using the modifier PD for eligible services in the 3 day (or 1-day) payment window no later than July 1, 2012. Additionally, hospitals and physician practices (or other part B entities) must have coordinated billing procedures for services subject to the 3-day (or 1-day) payment window in place no later than July 1, 2012.

Q.22. What if the hospital determines that non-diagnostic outpatient service(s) furnished within the payment window are not related to the inpatient admission?

A.22. Non-diagnostic preadmission services furnished within the payment window that are determined not clinically related to an inpatient admission are not subject to the 3-day (or 1-day) payment window policy. As such, the modifier PD would not be appended to the unrelated non-diagnostic service(s).

Q.23. Should condition code 51 be used to identify unrelated non-diagnostic services furnished in wholly owned or wholly operated physician practice (or other Part B entity)?

A.23. Condition code 51 is only used by the hospital when they bill separately for unrelated outpatient non-diagnostic service claims. The modifier PD would not be appended to an

unrelated non-diagnostic service furnished in a wholly owned or wholly operated physician practice (or other Part B entity). The absence of the modifier PD would serve as the attestation that the hospital that wholly owns or wholly operates the physician practice believes that the non-diagnostic service was unrelated to the hospital admission.

Q.24. Are all non-diagnostic services furnished on the date of admission considered related to the inpatient admission?

A.24. Yes, non-diagnostic services furnished by a wholly owned or wholly operated physician practice (or other Part B entity) on the date of a beneficiary's inpatient admission to the hospital are always deemed to be related to the admission. The admitting hospital's wholly owned or wholly operated physician practice (or other Part B entity) should use modifier PD to identify non-diagnostic services furnished on the date of a beneficiary's admission.

Q.25. What if a diagnostic service is unrelated to the inpatient hospital admission?

A.25. The Technical Component (TC) of all diagnostic services furnished by a wholly owned or wholly operated entity to a Medicare beneficiary who is admitted as an inpatient within 3 calendar days are subject to the 3-day payment window policy (or 1-day if applicable).

Q.26. How should a wholly owned or wholly operated physician practice bill for diagnostic services subject to the payment window?

A.26. The wholly owned or wholly operated physician practice (or other Part B entity) should only bill for the professional component of a diagnostic service subject to the 3-day (or 1-day) payment window. The modifier -26 and modifier PD must be appended to the diagnostic HCPCS code for the service. Please note that this policy has been longstanding and is unchanged since 1998.

Q.27. Should the wholly owned or wholly operated physician practice bill for the technical component of a diagnostic service?

A.27. No, the wholly owned or wholly operated physician practice (or other Part B entity) should not bill for the technical component (TC) of a diagnostic service subject to the payment window. The modifier PD does not apply to the TC of a diagnostic service. The TC of a diagnostic service (e.g. taking the x-ray) subject to the payment window is considered part of the admitting hospitals costs and therefore, included on the bill for the inpatient stay.

Q.28. Should the modifier PD be used for a patient in an Ambulatory Surgical Center?

A.28. Yes, a wholly owned or wholly operated Ambulatory Surgical Center (ASC) would use the modifier PD to identify outpatient physician or practitioner services subject to the 3-day (or 1-day) payment window.

Q.29. If a wholly owned or wholly operated physician practice furnishes a related outpatient evaluation and management (E/M) visit within the payment window, does the admitting hospital include any costs associated with the outpatient visit with the inpatient bill?

A.29 The wholly owned or wholly operated physician practice would bill the related outpatient E/M visit with modifier PD and the Medicare claims processing contractor would pay the physician practice at the facility rate. Medicare would pay the hospital for the direct practice expense associated with the related outpatient E/M visit through payment for the inpatient admission. Direct practice costs (clinical staff, equipment and supplies) for non-diagnostic services related to the inpatient admission provided by the wholly owned or wholly operated entity within the payment window are considered hospital costs and must be included on the hospital's bill for the inpatient stay and on the hospital's cost report.

Q.30. Should the modifier PD be used to identify outpatient physician or practitioner services, subject to the payment window, that are performed in the hospital?

A.30. No, the CMS modifier PD should not be used for outpatient services subject to the 3-day (or 1-day) payment window that are furnished in the hospital. For example, the modifier PD should not be appended to physician and practitioner professional services furnished in the hospital outpatient department, including the emergency department, patients receiving observation services, or other outpatient services furnished in a provider-based department of the hospital. The CMS modifier PD should only be used for diagnostic and related non-diagnostic outpatient services paid under the Medicare physician fee schedule that are furnished in a wholly owned or wholly operated physician practice (or other Part B entity) of the hospital. The modifier PD should not be appended to a claim where the payment window policy applies but the service was provided in a hospital. In other words, the modifier PD should be used to identify related outpatient services subject to the payment window furnished in the physician's office and not by the physician at the hospital.

Hospitals follow different billing instructions from a wholly owned or wholly operated physician practice (or other Part B entity) for billing outpatient services subject to the 3-day payment window furnished in an outpatient department of the hospital. (See the Medicare Claims Processing Manual, pub. 100-04, chapter 4, section 10.12 for billing instructions for hospitals furnishing outpatient services subject to the payment window policy.)

Q.31. Is the modifier PD required to be appended to services provided to an inpatient?

A.31. No, the modifier PD should only be used for outpatient services provided in the window prior to an inpatient admission subject to the payment window furnished in a wholly owned or wholly operated physician practice or other Part B entity. The modifier PD should not be applied to physician fee schedule claims for services provided after the patient has been admitted as inpatient to the hospital.

Q.32. Are rural health clinics (RHCs) or Federally qualified health centers (FQHCs) subject to the 3-day (or 1-day) payment window policy?

A.32. No, the 3-day (or 1-day) payment window policy does not apply to RHCs or FQHCs. Medicare pays for RHC and FQHC services through an all-inclusive rate that incorporates payment for all covered items and services provided to a beneficiary on a single day by an RHC/FQHC physician or practitioner; and related services and supplies. It is not possible to distinguish within the all-inclusive rate the amount of the payment for any particular patient that represents the professional versus the technical portion. Given that the 3-day payment window policy does not include professional services, and that RHCs and FQHCs are paid an all-inclusive rate that includes payment for professional services, RHCs and FQHCs currently are not subject to the 3-day payment window policy.

Q.33. Do I append modifier PD to "incident to" services?

A.33. Yes, if an admitted inpatient received services at a wholly owned or wholly operated entity prior to his or her admission and some of the services were furnished incident to a physician's or other practitioner's services, the physician would bill for those services according to the 3-day (or 1-day) payment window policy.

Q.34. How does the presence of the modifier PD affect the Medicare payment for non-diagnostic services?

A.34. For services without a technical and professional component split, modifier PD triggers the claim system to pay the facility rate without a TC/PC split (for example, outpatient physician's visit). In other words, the presence of modifier PD on professional non-diagnostic service codes, instructs the Medicare claims processing contractors to pay the "facility" payment amount in circumstances where, in the absence of the 3-day (or 1-day) payment window policy, the non-facility payment amount may have otherwise applied. The lower facility physician fee schedule payment reflects that the direct expenses associated with providing the service are now hospital costs and included on the hospital's inpatient bill rather than being paid to the physician.

Q.35. Should the modifier PD be appended to global surgical services furnished within the payment window?

A.35. Yes, a patient could have a surgical service furnished in a wholly owned or wholly operated physician office or other Part B entity within the payment window and, due to complications, be admitted as an inpatient within the payment window. In such cases, the physician practice would bill modifier PD with the specific surgical service code performed (for example, a diagnostic colonoscopy).

Q.36. Would there be circumstances in which the pre- and post- operative services included with the global surgical package are also subject to the 3-day payment window policy?

A.36. As indicated in publication 100-04, chapter 12, section 90.7.1, related surgical procedures furnished by a wholly owned or wholly operated physician practice (or other Part B entity) within the 3-day payment window are subject to the 3-day payment window policy. A surgical service with a global period payment would be subject to the 3-day payment window policy, when the wholly owned or wholly operated physician practice (or other Part B entity) furnishes the surgical service and the date of the actual outpatient surgical procedure falls within the 3-day payment window.

Q.37. When would the actual outpatient surgery and the pre- and post-operative services furnished during the global surgery time frame not be subject to the payment window policy?

A.37. If the initial surgical procedure that started the global period is furnished outside the payment window, the 3-day (or when applicable 1-day) payment window makes no change in billing a surgical service with a global period, even if some of the post-operative visits that are included in the surgical package occur in the 3-day payment window.

Q.38. Should a wholly owned or wholly operated physician practice bill for both the inpatient surgical procedure and initial related surgical procedure performed in the wholly owned or wholly operated physician office that started the global period under the 3-day payment window policy?

A.38. The 3-day payment window policy does not apply to inpatient services. The physician performing the inpatient surgical procedure would bill for the inpatient surgery service code according to normal Medicare rules (e.g. no modifier PD). The wholly owned or wholly operated physician practice would bill for the preceding outpatient surgical procedure with the modifier PD if the surgeon was part of the wholly owned or wholly operated physician practice.

Q.39. What Part B services are not subject to the 3-day (or 1-day) payment window?

A.39. Outpatient maintenance dialysis services and ambulance services are excluded from the pre-admission services that are subject to the payment window.

Q.40. Should the modifier PD be applied to outpatient services related to the inpatient admission when there is no Part A coverage for the inpatient stay?

A.40. No, the modifier PD should not be applied to related outpatient services when there is no Part A coverage for the inpatient stay. In the event that there is no Part A coverage for the inpatient stay, there is no inpatient service into which outpatient services must be bundled. Therefore, preadmission outpatient diagnostic and related nondiagnostic services furnished within the payment window would not be subject to the 3-day (or 1-day) payment window policy.

Q.41. Should the wholly owned or wholly operated physician practice (or other Part B entity) modify its actual charge for a related non-diagnostic service to accommodate a facility payment (instead of a nonfacility payment)?

A.41. The wholly owned physician practice should include its actual charge when submitting Part B claims for outpatient services subject to the 3-day (or 1-day) payment window. It is not required that the wholly owned physician practice modify its charge structure to accommodate a facility payment (instead of a nonfacility payment); although the physician practice may choose to do so.

Q.42. When did the 3-day (or 1-day) payment window policy become effective?

A.42. On February 11, 1998, beginning on page 6864 of the Federal Register, CMS published a final rule indicating that the payment window applies to diagnostic and related non-diagnostic outpatient services that are otherwise billable under Part B and does not apply to nonhospital services that are generally covered under Part A (such as home health, skilled nursing facility, and hospice). In addition, the rule defined an entity as hospital wholly owned or hospital wholly operated if a hospital is the sole owner of the entity or has the exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital also has policymaking authority over the entity. The 1998 final rule also defined non-diagnostic services as being related to the admission only when there is an exact match between the ICD-9-CM diagnosis code assigned for both the preadmission services and the inpatient stay. The 3-day payment window policy became effective March 13, 1998.

In the FY 2011 IPPS final rule, published August 16, 2010, beginning on page 50346 of the Federal Register, CMS discussed changes to the payment window policy (as required by section 102 of the PACMBPRA of 2010). Effective June 25, 2010 the payment window policy applies to non-diagnostic outpatient services clinically related to the inpatient admission furnished to a Medicare beneficiary by a hospital (or an entity wholly owned or wholly operated by the admitting hospital). The payment window policy for diagnostic services remained unchanged. The changes to the definition of "related to" the inpatient admission were implemented April 4, 2011 via CR 7142, Transmittal 796, published October 29, 2010.

Moreover, in the CY 2012 MPFS final rule, published November 28, 2011, beginning on page 73279 of the Federal Register, CMS finalized the payment window policy as required by the PACMBPRA of 2010, as it relates to wholly owned or wholly operated physician practices. The implementing manual instructions became effective January 1, 2012 with a compliance date of July 1, 2012.

Q.43. Where can I find more information about Medicare's 3-day payment window policy as it pertains to physician and practitioner services?

A.43. For more information on Medicare's 3-day payment window policy please review the following publications:

- **Change Request 7502, Transmittal 2373, published December 21, 2011 entitled "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 Practices."**
- **Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Sections 90.7 and 90.7.1.**
- **CY 2012 MPFS final rule, published November 28, 2011 (76 FR 73279 -73286).**