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November 9, 2011

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CMS's New Application of an Old Policy: The Three-Day Payment Window and Wholly-Operated Physician Practices

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There is a modicum of good news in the final CY 2012 Physician Fee Schedule (PFS). CMS has decided to delay until July 1, 2012, implementation of the expanded scope of the three-day payment window to non-provider-based physician practices and clinics. The rule also provides a billing code to identify those services, so that payments to these physicians may be appropriately identified and reduced. CMS's discussion of these changes can be found here: http://www.ofr.gov/(X(1)S(scowdohnuodekhblmbrwklwa))/OFRUpload/OFRData/2011-28597_PI.pdf

Background

Medicare has long required that most pre-admission services furnished prior to a beneficiary's inpatient admission to a hospital be "bundled" into the hospital's inpatient prospective payment (IPPS) rate if both (i) the entity furnishing the pre-admission services is wholly-owned or wholly-operated by the admitting hospital and (ii) the service is furnished within three days of the inpatient admission (or one day in the case of hospitals excluded from IPPS). The "bundled" services subject to the window include all pre-admission diagnostic services and most nondiagnostic services. The few services excluded are nondiagnostic services unrelated to the beneficiary's inpatient admission, ambulance services, and maintenance renal dialysis services.

As a practical matter, until recently, CMS also excluded from the "bundling" requirement those pre-admission nondiagnostic services furnished by non-provider-based wholly-owned or wholly-operated physician clinics or practices. In its recently issued physician fee schedule update for CY 2012, however, CMS has now included those practices within the payment window's ambit.

The CY 2012 PFS

CMS's final rule, which it placed on the web on November 1, 2011, closely tracks its earlier proposed rule with one notable exception. In the proposed rule, CMS anticipated implementing its rule change effective January 1, 2012. See 76 Fed. Reg. 42,772, 42,914-42,917 (July 19, 2011). CMS, however, has now pushed that date back. Recognizing that billing and accounting systems in hospitals and their wholly-owned or wholly-operated entities are not always coordinated, CMS now states that it will delay implementation of the new rule until July 1, 2012.

CMS limited the scope of the new rule to what was addressed in its proposal. The agency reminded hospitals that the payment window applies broadly to entities such as ambulatory surgical centers that are wholly-owned or wholly-operated by a hospital and that furnish pre-admission services, but it stated that it was addressing in the new rule only the policy's application to non-provider based, wholly-owned or wholly-operated physician practices and clinics. If needed, it said, it would address specifics related to other Part B entities in future rulemaking. Notably, CMS also excepted from the rule rural health clinics (RHCs) and federally qualified health centers (FQHCs).

In the final rule, CMS repeated the requirement that Medicare payment for the technical component of nondiagnostic outpatient services be bundled into the hospital's payment if the services are related to the admission, that is, if the services are clinically associated with the reason for the patient's inpatient admission. CMS further stated that if the nondiagnostic services at issue are considered by the hospital to be unrelated to the hospital admission, the hospital or wholly-owned/wholly-operated entity should document in the beneficiary's medical record the reasons why the services are not clinically related to the admission. If the pre-admission service falls within the three-day window, however, the hospital or the wholly-owned/wholly-operated entity will be expected to add payment modifier "PD" to the claim to reflect the need for "bundling."

The payment effect of the three-day window will be as follows. First, if the CPT/HCPCS codes at issue have a professional component (PC) and a technical component (TC) split, CMS will pay only the professional component. The agency will

assume that the technical component expense is incurred by the hospital and reimbursed through the DRG payment. Second, for codes without a TC/PC split, CMS will pay for the service at the "facility rate" to reflect that, again, the expense of technical resources associated with the pre-admission services have been incurred by the hospital. These reductions in the physician payment amount will apply to all diagnostic and related nondiagnostic services provided within the window, including drug therapies and imaging services. In some instances, as well, services furnished within a global surgical package might overlap with the three-day or one-day payment window and be subject to the rule's application.

It has not always been easy to identify whether certain entities are wholly-owned or wholly-operated by a hospital and, as such, whether they may fall within the three-day window. Historically, CMS has said that, for an entity to be wholly-owned, it must be solely owned by the hospital, and for the entity to be wholly-operated, the hospital must have exclusive responsibility for conducting and overseeing the entity's routine operations Beyond this, in 1998, CMS provided some common examples of what would and would not constitute being wholly-owned or wholly-operated. For some, however, the 1998 definitions and examples have been inadequate in that they fail to address the many ownership and operational structures that have developed over the years. Consequently, after the proposed rule was published, a number of commenters requested that CMS take the opportunity to furnish greater definition of these terms either issuing certain bright line tests or by furnishing very detailed examples of what it means to be wholly-owned and wholly-operated. In the final rule, however, CMS provided no further clarification, stating its belief that its long standing definitions of the terms wholly-owned and wholly-operated are appropriately descriptive. And, instead of providing new examples in its latest rule, CMS simply reprinted the examples contained in the 1998 rule and its responses.

Finally, CMS also addressed a commenter's concerns that the "minimally necessary" privacy standard required by HIPAA might not be met if hospital registration staff had access to the patient database at a physician's office. CMS responded that there would be no HIPAA violation if the hospital and physician's office staff were notifying each other about either admissions or furnished services for purposes of coordinating billing.

Ober|Kaler's Comments

All in all, it is not clear that CMS's expansion of the three-day payment window rule will have a significant effect on most hospitals or physician practices. Plainly, if the entity providing the pre-admission services is wholly-owned or wholly-operated by the hospital, there will be a reduction in the physician fee schedule payment just as though the service had been performed at the hospital itself. But how often this will occur is unclear. CMS has said that it does not know how many physician offices or clinics are wholly-owned or wholly-operated. Plainly, the impact on a specific organization will likely depend on that organization's ownership and operational structures.