# PUBLICATION

## Medicare's Three-Day Window is Fully in Effect: Are You in Compliance? [Ober|Kaler]

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**In Section 102 of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, Congress expanded Medicare's three-day payment window policy to apply to certain therapeutic services furnished by physician practices and other Part B entities that previously had not been subject to the rule. Subsequently, in the 2012 Medicare Physician Fee Schedule Final Rule, published November 28, 2011, CMS detailed its policies regarding the three-day payment window's application and then issued implementing manual instructions, which were published on December 21, 2011 (C.R. 7502). Finally, in mid-June of 2012, CMS issued Frequently Asked Questions (FAQs) to address common questions regarding the application of the three-day window payment policy. As a consequence, providers should now be aware of the policy and the need to conform to the policy.**

## Background

Medicare has long required that most pre-admission services furnished prior to a beneficiary's inpatient admission to be 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 three-day window include all pre-admission diagnostic services and most non-diagnostic services.

As a practical matter, until recently, Medicare excluded from the “bundling” requirement those pre-admission non-diagnostic services furnished by non-provider-based wholly owned or wholly operated physician clinics or practices. Congress, however, has now included those services within the payment window's ambit. Thus, as a result of the statutory change, all diagnostic services and all therapeutic services that are clinically related to the reason for the patient's inpatient admission are to be bundled into the hospital's DRG if furnished by a wholly owned or wholly operated entity within three days of the patient's admission. The payment window is three days – not 72 hours. Thus, it applies to services provided on the date of admission and during the preceding three calendar days, which could be longer than 72 hours.

## Application of the Three-Day Window

In order for the payment window provisions to apply, the hospital must wholly own or wholly operate the outpatient entity. For an entity to be wholly owned by a hospital, the hospital must be the sole owner of the entity. For the entity to be wholly operated by the hospital, the hospital must have exclusive responsibility for conducting and overseeing the entity's routine operations, regardless of whether the hospital has, as well, policymaking authority over the entity. Notably, if the hospital and the third party entity, including a physician office or other Part B entity, are “siblings,” both owned by a common third party such as a health system, the three-day window does not apply.

Determining whether the three-day window applies is not always easy. Because of the multitude of possible business and financial arrangements that may exist between hospitals and physician practices and other Part B entities, CMS does not make individual determinations as to whether specific physician practices or Part B entities are wholly owned or wholly operated by an admitting hospital. Rather, CMS states the hospital and its owned or operated physician practices or other Part entities are collectively responsible for making this determination. If the matter remains unclear, even after review by an entity's legal counsel, CMS's advice is that the entity essentially make the best determination possible and, if the determination is that the entity is not wholly owned or wholly operated and not subject to the payment window, that the entity maintain documentation to support that determination.

The payment effect of the three-day window is 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, again, that 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 non-diagnostic 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 payment window and be subject to the rule's application.

Operationally, the physician practices or other Part B entities should use a modifier PD to identify codes for services subject to the payment window period, with that modifier being required for services furnished on or after July 1, 2012. Only if the hospital determines that non-diagnostic pre-admission (“therapeutic”) services furnished within the payment window are not clinically related to the inpatient admission, and thus not subject to the three-day window, would the physician practice or other Part B entity not apply a modifier PD. The absence of the modifier will then serve to attest that the hospital believes that the non-diagnostic services were unrelated to the hospital admission. For diagnostic services, the wholly operated or wholly owned physician practice or the Part B entity should bill only for the professional component of the diagnostic service and append modifier -26 and modifier PD to the diagnostic code for the service.

Not all services are subject to the three-day window. The payment window does not apply to services furnished in rural health clinics or federally qualified health centers. Also, outpatient maintenance dialysis services and ambulance services are exempt or excluded from the window. Further, the payment window has limited application to critical access hospitals (CAHs). If the admitting hospital is a CAH, the payment window policy does not apply. If, however, the admitting hospital is a short stay acute care hospital paid under IPPS, and the CAH is wholly owned or wholly operated by that hospital, the outpatient's CAH services are subject to the window. Similarly, if the CAH is wholly owned or wholly operated by a psychiatric hospital and patient rehabilitation hospital, Children's hospital, cancer hospital or long term care hospital, outpatient CAH services furnished within one day of the patient's admission to such a hospital are bundled.

## Comments

Hospitals should have, by now, become familiar with the three-day window's application to wholly owned or wholly operated physician practices and related entities. All hospitals should have implemented changes to their billing practices to ensure compliance. In instances where questions remain, hospitals should consult with counsel to engage in a detailed analysis of whether the particular ownership or control structure might fall within the window.

Hospitals should be aware that these requirements apply not only to wholly owned or wholly operated physician practices. Other Part B entities that are wholly owned or wholly operated also fall within the ambit of the statute. Thus, for example, when a patient is seen in a wholly owned or wholly operated Ambulatory Surgical Center (ASC), the ASC would be required to use the modifier PD to identify the outpatient physician or practitioner services subject to the window. *See* FAQ # 28.