CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2373	**Date: December 21, 2011**
	Change Request 7502

Transmittal 2297, dated September 2, 2011, is being rescinded and replaced by Transmittal 2373, dated December 21, 2011, this CR is being reissued to 1) remove the sensitive and controversial instructions, 2) to finalize CMS payment modifier –PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within 3 days), and 3) to finalize our policy with a compliance date of July 1, 2012, as reflected in CY 2012 MPFS final rule (76 FR 73279) published on November 1, 2011. This instruction is being resent to change the effective dates on the manual instruction from January 10, 2012 to January 1, 2012. All other information remains the same.

SUBJECT: 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

I. SUMMARY OF CHANGES: For services on or after January 1, 2012, when a patient is seen in a wholly owned or wholly operated physician practice and is admitted as an inpatient within 3-days (or, in the case of non-IPPS hospitals, 1 day); the 3-day payment window will apply to diagnostic and nondiagnostic services that are clinically related to the reason for the patient's inpatient admission regardless of whether the inpatient and outpatient diagnoses are the same.

EFFECTIVE DATE: January 1, 2012
IMPLEMENTATION DATE: January 3, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Table of Contents
N	12/90.7/Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (including Physician Practices and Clinics): 3-Day Payment Window
N	12/90.7.1/Payment Methodology: 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (including Physician Practices and Clinics)

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2373	December 21, 2011	Change Request: 7502

Transmittal 2297, dated September 2, 2011, is being rescinded and replaced by Transmittal 2373, dated December 21, 2011, this CR is being reissued to 1) remove the sensitive and controversial instructions, 2) to finalize CMS payment modifier –PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or wholly operated entity to a patient who is admitted as an inpatient within 3 days), and 3) to finalize our policy with a compliance date of July 1, 2012, as reflected in CY 2012 MPFS final rule (76 FR 73279) published on November 1, 2011. This instruction is being resent to change the effective dates on the manual instruction from January 10, 2012 to January 1, 2012. All other information remains the same.

SUBJECT: 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 Entities

Effective Date: **January 1, 2012**

Implementation Date: January 3, 2012

I. GENERAL INFORMATION

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 thus, 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."

Policy: Payment Methodology

CMS shall establish 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.

More detail is found in the Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Sections 90.7 and 90.7.1.

I. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7502.1	Contractors shall apply the policies described in the Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Sections 90.7 and 90.7.1	X		X	X						
7502.2	When the modifier PD is appended to a service furnished on or after January 1, 2012, contractors shall pay at the facility rate.	X			X			X			
7502.3	When the PD modifier is appended to a globally billed service, i.e., a service for which both professional and technical components apply, and the service is billed without a -26 or TC modifier, contractors shall apply their routine procedures for not paying the TC component, e.g., denying or rejecting the claim or paying for only the professional component.	X			X						
7502.4	When the PD modifier is appended to a service which could be globally billed, i.e., a service for which both professional and technical components apply, and the service is billed with a TC modifier, contractors shall deny the claim.	X			X						
7502.4.1	For claims denied per BR 7502.4, contractors shall use	X			X						

	the following Claim Adjustment Group Code: **CO Contractual Obligations**										
7502.4.2	For claims denied per BR 7502.4, contractors shall use the following Claim Adjustment Reason Code: A1 **Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)**	X			X						
7502.4.3	For claims denied per BR 7502.4, contractors shall use the following Remittance Advice Remark Code: **M96 The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only**	X			X						
7502.4.4	For claims denied per BR 7502.4, contractors shall use the following Medicare Summary Notice messages, including their Spanish translations, as noted: **16.45 You cannot be billed separately for this item or service. You do not have to pay this amount.** Usted no puede ser facturado separadamente por este artículo o servicio. Usted no tiene que pagar esta cantidad. AND **21.7 This service should be included on your inpatient bill.** Este servicio debe ser incluido en su factura de paciente interno.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7502.5	When this instruction is no longer sensitive, a provider education article related to this instruction will be	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
7502.1	CR 7142 Clarification of Payment Window for Outpatient Services treated as inpatient Services

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): For policy please contact Stephanie Frilling at (410) 786-4507 or Stephanie.Frilling@cms.hhs.gov. For Payment and Billing please contact Claudette Sikora at (410) 786-5618 or Claudette.Sikora@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be

outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents

(Rev.2373, Issued: 12-21-11)

90.7 - Bundling of Payments for Services Provided in Wholly Owned and Wholly Operated Entities (including Physician Practices and Clinics): 3-Day Payment Window

(Rev.2373, Issued: 12-21-11, Effective: 01-01-12, Implementation: 01-03-12)

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 thus, 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, unless the nondiagnostic services are unrelated to the inpatient hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's inpatient admission). In such cases, the unrelated outpatient hospital nondiagnostic services are covered by Medicare Part B, and the hospital or wholly owned or wholly operated physician practice shall include the technical portion of the services in their billing. 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.

Implementation of the 3-day Payment Window Policy in Wholly Owned or 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 (preceding1 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. Only unrelated nondiagnostic preadmission services are not subject to the payment window policy, where unrelated preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's inpatient admission and are furnished on the 1st, 2nd, or 3rd calendar day immediately preceding the date of the inpatient admission. (Note: nondiagnostic services furnished by a wholly owned or wholly operated physician practice on the date of a beneficiary's inpatient admission to the hospital are always deemed to be related to the admission and their technical portion must be included on the bill for the inpatient admission.) 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 three-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.

Definition of Wholly Owned or 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."

90.7.1 Payment Methodology: 3-Day Payment Window in Wholly Owned or Wholly Operated Entities (including Physician Practices and Clinics)
(Rev. 2373, Issued: 12-21-11, Effective: 01-01-12, Implementation: 01-03-12)

CMS has established HCPCS payment modifier PD (Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated physician office to a patient who is admitted as an inpatient within 3 days), and requires that the modifier be appended to the physician 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 physician's office 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 practice of an inpatient admissions for a patient who received services in a wholly owned or wholly operated physician office within the 3-day (or, when appropriate,1-day) payment window prior to the inpatient stay. The modifier is effective for claims with dates of service on or after January 1, 2012. Wholly owned or wholly operated per their readiness to do so. Entities have the discretion to apply these policies for claims with dates of service on and after January 1, 2012, but shall comply with these polices no later than 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-day (or, in the case of non-IPPS hospitals, 1-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 physician office and then, due to a complication, be admitted to the hospital as an inpatient. In such cases the modifier shall be appended to the appropriate surgical HCPCS/CPT code.