



May 23, 2012

Marilyn B. Tavenner
Centers for Medicare & Medicaid Services
Acting Administrator
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Rescission of three-day payment window expansion

Dear Administrator Tavenner:

The Medical Group Management Association (MGMA) requests that the Centers for Medicare & Medicaid Services (CMS) rescind its decision to pay for physician services using the facility rate for the physician component of diagnostic services and for non-diagnostic services that: 1) are performed in the three days prior to an inpatient admission; 2) are related to the admission; and 3) are performed in a physician practice that is wholly owned or operated by the hospital to which the patient was admitted. MGMA expressed its strong concerns about this policy when it was proposed in the 2012 Medicare physician fee schedule. CMS subsequently delayed implementation for six-months, but MGMA maintains the provision will unnecessarily create large burdens and increase uncertainty for group practices that are wholly owned or operated by a hospital. These burdens far outweigh CMS's stated interests in pursuing this change.

MGMA-ACMPE is the premier association for professional administrators and leaders of medical group practices. Since 1926, the Association has delivered networking, professional education and resources, advocacy and certification for medical practice professionals. The Association represents 22,500 members who lead 13,600 organizations nationwide in which some 280,000 physicians provide more than 40 percent of the healthcare services delivered in the United States.

The new rule would require hospitals to notify a wholly owned or operated physician practice (or other entity) when a patient seen at the practice is subsequently admitted for an inpatient stay within three days of the office visit. Upon notification from the hospital, the physician practice would include a new Healthcare Common Procedure Coding System (or HCPCS) modifier (PD) on its claim for the office visit, notifying CMS that this claim should be paid at the lower facility rate. In delaying this change from Jan. 1 to July 1, CMS itself expressed concern that "many hospitals and their wholly owned or wholly operated entities will not be able to establish internal procedures and communications pathways needed to comply...."

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Even if the affected healthcare providers are able to coordinate their billing and accounting systems, this policy should be rescinded because of the needless administrative burdens and potential penalties it places on practices. Under the best circumstances, practices that are wholly owned or operated by hospitals would face a delay in submitting claims for all Medicare encounters. While CMS emphasizes that “the 3-day payment window is a hospital requirement” and that “hospitals can assist their wholly owned or operated entities in managing the unique aspects of billing for services subject to the payment window policy,” practices face the risk of any errors or oversights.

For example, if a practice submits a claim without receiving word from the hospital that its patient was subsequently admitted as an inpatient, the practice will not have had the opportunity to attach a modifier to its claim and will be paid at the higher, non-facility rate. If the practice does not learn of this omission immediately, it is in danger of keeping an overpayment from Medicare which, after 60 days, becomes a false claim subject to all the penalties of the False Claims Act as a result of Section 6402 of the Affordable Care Act. If the practice does become aware of the error, it will need to resubmit the claim and return the difference in payment between the facility and non-facility rate to the government. Depending on the structure of the relationship between the hospital and the practice, this decreased payment may not be justified.

As relationships between hospitals and physician practices continue to evolve, there are countless forms that they can take. CMS should recognize the unique collaborations that hospitals, group practices and other healthcare providers have formed and avoid setting payment policies that dictate their structure. We urge CMS to reconsider this policy. Should you have any questions please contact Amy Nordeng at anordeng@mgma.com or 202-293-3450.

Sincerely,

A handwritten signature in black ink that reads "Susan Turney". The signature is written in a cursive, flowing style.

Susan Turney, MD, MS, FACP, FACMPE
President and CEO

CC:

Amy Bassano, Director, Hospital & Ambulatory Policy Group, CMS
Stewart Streimer, Director, Provider Billing Group, CMS