Changes to Medicare's "3-Day DRG Payment Window" Policies

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Friday, October 7, 2011

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Agenda

- Overview of 3-Day DRG Payment Window
- Understand recent change; CMS clarifying existing policy
- Implications for hospitals that own or operate physician offices and other off-campus facilities
- 2012 Physicians Fee Schedule Final Rule expected November 2011
  - All attendees will receive written update of any changes

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Big Picture

- Hospitals that wholly own or operate physician practices required to bundle services performed within 3 days prior to admission in the inpatient bill
  - "Exact Match" rule for non-diagnostic services gone, now "clinically associated"
  - Medicare physician payment to hospital-owned, free-standing practices reduced when TC portion of services are bundled with the inpatient claim
  - Hospital revenues will decrease
  - Physicians paid on a % of collection in these settings will see incomes decrease

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Bottom Line

- Decreased Medicare revenue in formerly freestanding settings
- Increased billing complexity for both Part A and B
- May require rethinking leaving wholly-owned physician practices as “freestanding” and cause systems to convert to provider-based status

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History of 3 Day Window

- Proposed rule issued 1/12/1994 (59 FR 1654)
- Final rule issued 2/11/1998 (63 FR 6864)
- Outpatient services provided to patient in hospital’s wholly owned or operated entities w/in 3 days of admission are bundled in I/P claim
  - 3 calendar days, not 72 hours prior to admission
  - Includes entities that are treated as free-standing by the hospital

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History of 3 Day Window

- Diagnostic services provided within 3 days of admission are always bundled
- Preadmission non-diagnostic services were also supposed to be bundled
  - But *only* when exact match between ICD-9 principal diagnoses code(s)
  - Application of non-diagnostic services was rarely implemented by hospitals and rarely, if ever, enforced by CMS. (CMS has acknowledged)

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History of 3 Day Window

- Despite lack of enforcement, many hospitals automatically bundled everything (TC) in outpatient departments (whether required or not)
  - Including those unrelated to admission per ICD-9 exact match
  - RACs went after hospitals that bundled unrelated services because of the chance of obtaining outlier payments on the DRG
- Bundling does not apply to nonhospital services such as HHA, SNF and hospice

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Initial Issue Prior to 2010

- Several law firms and consulting firms recommended their client reopen claims to unbundle and re-bill where ICD-9 exact match not made
- Congress and CMS paid attention
- We believe CMS did not realize hospitals were bundling all services, not just those related to admission

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Current 3 Day Window

- Amended 6/25/2010 in Section 102 of the "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010" (Pub L. 111-92) ("PACMBPRA"!!)
  - Effective for O/P services provided on/after 6/25/2010
  - Published in 2011 IPPS Final Rule (8/16/2010 Federal Register)
  - Added prohibition to keep Medicare from reopening a claim, adjusting a claim or making payments for treating services unrelated to admission

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Current 3 Day Window

- Published in IPPS Final Rule 8/16/2010 Federal Register (cont.)
  - No changes made to billing of diagnostic services furnished 3 days prior to admission
  - Preadmission non-diagnostic services treatment changed

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Current 3 Day Window

- For non-diagnostic preadmission services, ICD-9 codes no longer required to be exact match
  - But be "clinically associated" w/inpatient admission
  - Outpatient CPT-4 codes are converted to ICD-9 codes on I/P claim
  - May affect MS-DRG assignment
- Non-related services still billed as outpatient
- Again, still excluding maintenance dialysis and ambulance services

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Current 3 Day Window

- CMS noted in 8/16/2010 FR that 1998 policy was generally unknown to hospitals
- Secretary deemed bundling rule w/n have negative impact on rural hospitals
  - Defined as hospital under 100 beds outside of urban area
  - Exception: New England hospitals all deemed urban
  - Thus, rule went forward as final

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Current 3 Day Window

- CMS has taken the position that the 1998 rule 2/11/1998 (63 FR 6864) did apply to non-diagnostic services as well, but only when there was an exact match on ICD
  - "Effective March 13, 1998, we defined non-diagnostic preadmission services as being related to the admission only when there is an exact match (for all digits) between the ICD-9-CM principal diagnosis code assigned for both the preadmission services and the inpatient stay." MCPM CMS Pub 100-04 §40.3.C

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Current 3 Day Window

- For hospitals not a "subsection (d) hospital" (psych, rehab, LTCH, children's, cancer), bundling required for services provided 1 day prior to admission
  - Published in 9/1/1995 Federal Register (60 FR 45840)
  - Day refers to entire day preceding admission, not 24 hours
- Critical Access Hospitals exempt from bundling rules

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Current 3 Day Window

- CMS established process for hospitals to *attest* that non-diagnostic services are unrelated to the hospital admission
  - Hospital attestation process
  - Issued in Change Request (CR) #7142
  - Implementation date of 4/4/2011, for dates of service 4/1/11 and after

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Required Hospital Attestation

- If O/P services not related to admission, hospital attests when submitting O/P claim
  - Hospital adds Condition Code 51 - Attestation of Unrelated Outpatient Non-diagnostic Services
    - May have required retroactive adjustments by hospital for services provided after 6/25/10, if claim rejected by Medicare
    - Documentation to be maintained in beneficiary's medical record to support claim
  - Subject to subsequent CMS review

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Proposed Payment Rate Changes

- Physician payment for PC at physician clinic at same physician payment rate as provider-based clinics
  - Reduced physician payment avoids duplicate payment for facility services (technical component) since facility component bundled on I/P claim
  - Incident-to (nurse-only) billing

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Proposed Payment Rate Changes

- New Medicare HCPCS modifier to be established
  - To signify professional service s/b paid at provider-based rate (SOS differential)
  - Modifier appended to HCPCS code for applicable pre-admission services provided
  - Modifier effective as of 1/1/2012
- CMS will no longer separately pay the TC bundled services
- CMS will modify regulation defining sites of service (SOS) to add SOS for entity "wholly owned or operated by a hospital"
- CMS to provide more detailed instructions in 2012 Final Physician Fee Schedule Rule published in November 2011

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Hospital Owned/Operated

- 42 CFR §412.2(c)(5) and 42 CFR §413.40(c)
- Hospital is sole operator of entity if:
  - Hospital has exclusive responsibility for conducting/overseeing entity's routine operations
    - Does not need to have policymaking authority

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Hospital Owned/Operated

- 42 CFR §412.2(c)(5) and 42 CFR §413.40(c)
  - CMS indicates that physician practices self-designate whether owned or operated by a hospital during Medicare enrollment process
    - Check your CMS form 855B
    - Hospitals, check your CMS form 855A
    - Check state corporate practice of medicine (CPM) law & articles of organization – CMS may have been carefully avoiding referencing professional medical aspects of the practice

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Claims Processing Issues

- Hospital will need to ensure "wholly owned or operated entities" are informed of inpatient admissions
- Hospitals and physician clinics will need to be more closely aligned
  - Outsourced billing vendors will need to be brought into the fold

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What Physician Practices are Included?

- Refer back to 2/11/1998 Federal Register for examples
  - We understand CMS will use same examples from this rule
- CMS clearly referencing "physician practices"
- Provider-based departments (*Note*: CMS thinks provider-based departments were already covered properly)
- California 1206(d) practices (provider-based)
- Hospital "operated" (even if not "owned")
- Hospital "managed" ??? (depends on scope of service)

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What Physician Practices are Included?

- Some hospitals have carved-out licensed space and not treated location as provider-based
- Physicians practicing in these locations billed with POS 11 (physician office) rather than POS 22 (outpatient hospital) – physician claims not reduced by site of service differential
- These locations are impacted unless redesigned

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What Physician Practices Should *Not* Be Included?

- Medical office building where hospital is merely a landlord
- Owned by the hospital parent, other health system (non-hospital) affiliate
  - CMS deems these to be owned by a "third party" (personal communication, September 29, 2011)
- Manager is separate entity from hospital
- Joint Ventures – so long as not wholly-operated or provider-based
- Independent lab used for preadmission testing
  - Not bundled as lab does not do testing "under arrangement" with admitting hospital

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Global Surgery Issues

- Global surgeries have period of 0, 10 or 90 days
  - Medicare payment includes preop visits, intra-op visits, complications following surgery, post op visits, postsurgical pain mgmt, supplies, and misc other services such as suture/staple removal
  - Time frame for 3-day payment window and global surgical package may overlap

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Global Surgery Issues

- If surgical procedure done within 3-day window
  - Practice (aka “technical” or “facility”) expense should be included on Hospital’s Part A claim form
  - Practice will apply the new HCPCS modifier
  - Medicare pays practice for the professional component at the facility rate, same that a provider-based clinic would receive

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Global Surgery Issues

- If surgical procedure done outside 3-day window
  - Guess what! 3-day window policy would not apply!
  - CMS does not deem it appropriate to unbundle post op services
  - Services not part of global surgical procedure still subject to potential 3-day window

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Issues to Deal With

- How will hospitals/physician practices implement changes in billing to ensure bundling done appropriately?
  - Will there be a delay in claims dropping?
- CMS recognizes separate ICD-9 coding guidelines in I/P and O/P setting
  - Believes bundling rules do not impact coding guidelines

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Issues to Deal With

- What will CMS deem as "clinically related" to an inpatient admission?
  - CMS did say sticking with "exact match" would be "too narrow" (76 F.R. at 51707, 8/18/2011)
  - Likely would have been difficult under ICD-10
  - Clarification may not be to hospital's liking
    - Per 9/29/2011 communication with CMS, may be leaving it up to hospitals to determine

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Issues to Deal With

- CMS believes full adoption of EMR will facilitate coordination and tracking of patients
- What about hospitals in States that own free-standing physician practices but physicians do their own billing?
  - i.e., States with Corporate Practice of Medicine doctrines

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Issues to Deal With

- Should you convert your clinics to provider-based status?
  - Opportunity to revisit provider-based status vs freestanding for various services
  - Immediate review of impact on revenue and operations required

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Issues to Deal With

- Reasons hospitals did not want to treat various locations as provider-based:
  - Impact on beneficiaries of separate coinsurance/deductible
  - Administrative burdens of compliance with 42 CFR 413.65 (licensure, medical records, billing)
  - Reduction to physician compensation (site of service differential)
  - Concern that OIG not supportive of provider-based physician practices
  - Allow physicians greater sense of "independence" from the hospital administration

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Issues to Deal With

- Does the new rule require re-evaluation of these objections?
  - Physician PCs are going to be reduced if "clinically associated" with inpatient admission.
    - This does not apply to all physician services – outpatient only services are not impacted
    - If CMS seeks to extract revenues from these settings, no reason not to offset through legal, legitimate system redesign
  - Flexibility and independence of freestanding practices further eroded

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Issues to Deal With

- Health reform payment model changes (bundled, accountable care, etc.) require greater integration of hospitals and physicians in any event

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Questions and Answers

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