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Hospitals Get Brief Delay in DRG Window Rule, but No Clarity on 'Related' Services

CMS has given hospitals an extra six months to comply with the DRG window payment policy at physician practices they own or operate, according to the final 2012 Medicare physician fee schedule regulation, announced Nov. 1.

As of July 1, 2012, hospitals must bundle into their inpatient claims the diagnostic and "clinically related" nondiagnostic services provided at their freestanding clinics up to three days before admission. That will trigger cuts in hospital and physician payments, partly through the use of a modifier unveiled in the regulation.

The DRG window payment rule already applies to provider-based entities, which are essentially hospital outpatient departments. But now CMS has extended it to almost all outpatient entities owned or operated by hospitals, such as labs and ambulatory surgery centers, according to the rule, which is slated for publication in the Nov. 28 *Federal Register.* No bundling into the MS-DRG is necessary, however, for "clinically unrelated" nondiagnostic services.

The DRG window payment policy extension was introduced in the 2012 inpatient prospective payment system regulation (RMC 8/8/11, p. 5), and the Medicare physician fee schedule is its companion, fleshing out physician reimbursement logistics and other details.

Starting July 1, Medicare won't pay separately for the technical component of outpatient diagnostic or clinically related nondiagnostic services when provided up to three days before admission. The global physician fee schedule payment that Medicare pays freestanding clinicians will no longer include the facility component for outpatient services subject to the DRG payment window. Physicians will obviously still get paid, but at a lower rate, like that of provider-based clinics.

CMS is reducing physicians' fees for diagnostic and clinically related nondiagnostics provided up to three days before admission at hospital-owned or operated clinics because hospitals pick up the tab for office expenses, such as nurses and equipment.

Physicians Must Now Use a New Modifier

Physicians must start appending the newly created modifier "PD" to inform Medicare carriers when the technical portion of their services are bundled into the inpatient claim and payment to the wholly owned entity should be at the facility rate. The modifier for diagnostic or related nondiagnostic services provided in a wholly owned or operated entity to a patient who is admitted within three days will be available for use on the HCFA 1500 physician billing form Jan. 1, but it's not required until July 1, says Cheryl Storey, a health care partner in the accounting firm Moss Adams LLP.

CMS gave hospitals a reprieve because it acknowledged the burdens of coordinating hospital and physician billing.

Lawyers see flaws in the regulation that will make life harder for hospitals. For one thing, CMS again failed to define "clinically related," says Boston attorney Larry Vernaglia, with Foley & Lardner LLP. CMS said hospitals will have to take it as it comes. "We believe that determining whether an outpatient service is 'clinically related' requires knowledge of the specific clinical circumstances surrounding a patient's inpatient admission and can only be determined on a case-by-case basis."

With this regulation, CMS has gone from one extreme to the other, Vernaglia says. It used to require bundling only when there was a five-digit ICD-9 coding match between outpatient and inpatient diagnoses in the three-day window. "Now CMS is saying an analysis has to be done regardless of the similarity of the diagnosis," he says. Hospitals might consider bundling everything and "letting the RACs sort it out," he adds.

CMS also said that hospitals must document their justification for outpatient services that are not clinically related to the admission. "That means you have to prove a negative," Vernaglia says. The only way to do that, he contends, is to evaluate every preadmission nondiagnostic service provided at clinics owned or operated by hospitals, and then put something in the med-

ical record about why you are not bundling it. Suppose a depressed diabetic patient who receives therapy at the hospital-owned clinic is then admitted to the hospital for an amputation. "There probably is some clinical association but there is zero overlap of diagnoses," he notes, and that's why it shouldn't have to be bundled. That means hospitals deserve separate reimbursement for those preadmission services. "It will be a challenge for providers to look at everything in non-provider based entities and do a case-by-case analysis clinically."

On a brighter note, the final regulation excluded rural clinics and federally qualified health centers (FQHCs), which will be a relief to hospitals, Storey says. "Hospitals routinely are patrons of FQHCs and it's nice the regulation doesn't introduce another level of uncertainty," according to Vernaglia. Anyway, payments for services provided at rural clinics and FQHCs are all-inclusive, Storey says, "and CMS recognizes the improbability of segregating the professional component from the technical component."

Rural Clinics and FQHCs Are Excluded

But she says CMS seems to have the illusion, based on the regulation, that hospitals rarely own or operate practices other than provider-based facilities, Storey says (RMC 1/17/11, p. 1). They overstated the case, but given CMS's extension of the DRG payment policy, maybe it's better to give in.

"Now is the time to change to provider-based status because, according to the final rule, CMS thinks all your wholly owned entities are already provider-based. You might as well make it real," she says. Medicare pays more for services provided at provider-based entities, although there are downsides with the designation, such as higher patient copays and scrutiny from the HHS Office of Inspector General.

CMS also suggests transferring the costs of preadmission services at wholly owned practices to appropriate hospital departments on the Medicare cost report so revenue and expenses match. "This means hospitals will need to make adjustments in their cost reports to add applicable costs from the wholly owned entities to hospital departments for use in calculating a cost-to-charge ratio," she says. Charges for preadmission services already will be included in Part A Medicare charges, so "the hospital will need to be sure the related costs are reported as well," Storey says.

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