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CMS Clarifies DRG Window Payment Rule as Extension Takes Effect

CMS recently published guidance on its extension of the three-day DRG window payment policy to physician practices that are wholly owned or operated by hospitals. There are now answers to 43 frequently asked questions (FAQs) on so-called "DRG window unbundling," which are analyzed below by Larry Vernaglia, chair of the health law practice group at Foley & Lardner in Boston, and Cheryl Storey, a health care partner in the accounting firm of Moss Adams LLP. As of July 1, 2012, hospitals must bundle into their inpatient claims the diagnostic and clinically related nondiagnostic services provided at their freestanding clinics within three days of admission. Hospital-owned and operated physician practices were added to the DRG window payment policy in both the 2012 inpatient prospective payment regulation and Medicare physician fee schedule regulation (RMC 10/17/11, p. 1). *This will trigger cuts in hospital and physician payments, partly through the use of a modifier unveiled in the regulation* (RMC 11/7/11, p. 1). *Contact Vernaglia at lwv@foley.com and Storey at cheryl.storey@mossadams.com.*

On July 9, 2012, CMS announced a number of Frequently Asked Questions (FAQs) in response to concerns and inquiries about the application of the three-day DRG window bundling rule for freestanding practices wholly owned or operated by hospitals. These FAQs provided further clarification of CMS's take on the issue, which was discussed in the Final Physician Fee Schedule regulations (76 FR 73285-73286) and later in Change Request (CR) 7502. Although the FAQs provide additional guidance on the extension of DRG window unbundling to hospital-owned or operated physician practices, CMS is still leaving quite a bit up to interpretation, so it will be important for hospitals and health systems to document their approaches on several of the issues in CR 7502.

More CMS Guidance Would Be Helpful

Despite a number of questions from the provider community, CMS provided little additional guidance on what "wholly owned or operated" means, nor will it make a determination of whether the entity meets the definition of "wholly owned or operated" (see FAQs 11 and 12). One particularly important question is whether "membership" in a nonprofit organization would qualify as "ownership" for purposes of the rule. Virtually every state corporate law would require the conclusion that membership in a nonprofit corporation is not ownership. But the absence of direct guidance from CMS on this issue is troubling, particularly where CMS appears not to want providers to reach out to the intermediaries or MACs for approval or acknowledgement of the providers' determinations. Consequently, it will be incumbent upon the entities to document their ownership and operational issues if they believe their free-standing entities are not subject to the three-day bundling rules (FAQ 14).

CMS provided a few examples of cases that would not trigger the wholly-owned or wholly-operated definition. According to FAQ 10, the three-day bundling rule does not apply in the following circumstances:

- If the hospital or physician office or other Part B entity are both owned by a third party, such as a health system;
- If the hospital is not the sole or 100% owner of the entity, such as joint ownership, or if physicians or other practitioners have an ownership interest in the hospital, physician practice or Part B entity; and
- A "financial or administrative partner" can interrupt the chain of ownership between a hospital and a free-standing organization, thus avoiding the bundling rule (unless, of course, the organization is wholly operated by the hospital).

CMS also provided useful clarifications of claims-documentation requirements. It's good news that the charges on the free-standing claim (CMS 1500) need not be adjusted if a portion of the service is bundled on the inpatient claim (FAQ 41). However, the hospital will need to set up in its system the technical portion of the services provided in the freestanding setting so those services can be bundled on the inpatient claim. CMS states that the technical portion of the services are "considered hospital costs and must be included on the hospital's bill for the inpatient stay" (FAQ 19).

CMS doesn't shed any more light on what it means for a service to be "clinically related." While all diagnostic services must be bundled on the inpatient claim if provided within three days of admission, non-

diagnostic services have to be bundled only if they are clinically related to the inpatient admission. What CMS means by this remains fuzzy. The agency reiterated that diagnosis codes don't need to be an exact match to indicate they are clinically related, but CMS will not provide a definitive list of services that are clinically related and the determination of "clinically related" is to be made by the hospital on a case-by-case basis (FAQs 16 & 17). Consequently, hospitals will need to make their own determinations on whether a service is clinically related. Deciding this on a case-by-case basis could (if taken literally) result in an immense administrative burden. Hospitals should be able to establish policies and protocols on broad categories of services that are or are not clinically related to the inpatient admission.

When hospitals determine the services *are* clinically related, they use modifier PD on the CMS 1500 claim form to indicate the technical component of the services is bundled on the inpatient claim and the physician service should be paid at a reduced rate. This applies a site-of-service differential to the physician fee schedule payment. The reduced rate is the same amount that would be paid for the physician service if the physician service were provided in an outpatient provider-based department. Hospitals are to attest when the non-diagnostic services are clinically unrelated to the inpatient service and should be paid at the full amount of the physician fee schedule. *An interesting point:* CMS said the "attestation" is the *absence* of the PD modifier on the CMS 1500 claim (FAQ 23).

Although critical access hospitals (CAHs) are not subject to the DRG window payment policy, there is a little something for them in the new guidance. CMS indicated that, if a hospital wholly owns or operates a critical access hospital, any outpatient services provided there are subject to the three-day bundling rules if the patient is admitted at the hospital that owns the CAH facility (FAQ 5). Take note, however, that the PD modifier is used only for services provided in the freestanding outpatient setting. Modifier 22 is used when billing physician services provided in provider-based outpatient settings.

The three-day DRG payment window requirements have undergone significant change and reinterpretation in the past two years. Providers may not be aware of these changes, and they should review the FAQs as well as the preamble to the CY 2012 Physician Fee Schedule Final Rule, referenced above. Failure to properly treat the services at freestanding but wholly owned or wholly operated physician practices may result in incorrect payment.

To review CMS's 43 new FAQs, go to http://tinyurl.com/7aehv99. ✧