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## CMS Issues Medicare Inpatient Prospective Payment System Fiscal Year 2012 Final Rule

### *Final Rule Impacts Three Key Medicare Policies*

On August 18, 2011, the Centers for Medicare and Medicaid Services (CMS) issued the Medicare Inpatient Prospective Payment System Fiscal Year 2012 Final Rule (2012 IPPS Final Rule). The effective date for these provisions is October 1, 2011. As summarized on the Fact Sheet CMS issued along with the 2012 IPPS Final Rule, hospitals are well-advised to review its many significant provisions. [Click Here](#) to view CMS's Fact Sheet. This alert focuses on three particularly important provisions: 1) clarification of CMS policy regarding the application of the Three-Day Payment Window to services furnished in hospital-owned or operated physician practices, 2) clarification of CMS policy regarding the provision of inpatient services under arrangement, and 3) changes in methodology for the determination of pension costs.

#### **Broadened Application Of The Three-Day Payment Window To Services Furnished In Hospital Wholly Owned Or Operated Physician Practices**

The Three-Day Payment Window requires the bundling along with payment for inpatient services of certain preadmission services provided to a Medicare beneficiary by the admitting hospital, or by **an entity wholly owned or wholly operated** by the admitting hospital, within three days prior to and including the date of the beneficiary's admission. See 42 CFR 412.2(c)(5). For purposes of the Three-Day Payment Window, an entity is "wholly owned" by a 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. See 42 CFR 412.2(c)(5)(i). Accordingly, "[a] hospital-owned or hospital-operated physician clinic or practice is subject to [the Three-Day Payment Window]." See 63 FR 6866.

Originally, the Three-Day Payment Window required an exact match between the principal ICD-9 CM diagnosis codes (ICD-9 codes) for the outpatient services and the inpatient admission. Thus, certain preadmission nondiagnostic services performed at hospital-owned or hospital-operated physician practices/clinics were not subject to the Three-Day Payment Window because the ICD-9 codes for such practices/clinics' outpatient services did not exactly match the ICD-9 codes for the admitting hospitals, even if such hospitals owned the practices/clinics. The Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act

of 2010 (the 2010 Act), however, provided that all clinically related nondiagnostic services performed by a hospital (or a hospital-owned or hospital-operated entity), within the preceding three days of the inpatient admission must be included on the claim for the inpatient stay, regardless of whether the hospital's ICD-9 code exactly matched its subsidiary's ICD-9 code. As a result, an increased number of nondiagnostic preadmission services performed at hospital-owned or hospital-operated physician practices/clinics became subject to the Three-Day Payment Window.

In the 2012 IPPS Final Rule, CMS provided clarification regarding two important aspects of the Three-Day Payment Window in the context of services furnished in hospital-owned or hospital-operated physician practices/clinics. [Click Here](#) for a copy of the relevant Federal Register preamble discussion. First, CMS stated that the 2010 Act "broadens the applicability of the payment window policy in hospital-owned or hospital-operated physician offices or clinics" with respect to nondiagnostic preadmission services. CMS explained that in order to bill the nondiagnostic preadmission services separately, the hospital (and hospital-owned or hospital-operated entity) "must now attest that the services are not related to an admission by using condition code 51 (Attestation of Unrelated Outpatient Nondiagnostic Services) when billing for services." Second, CMS also clarified that the Three-Day Payment Window will apply to the related nondiagnostic preadmission services of "wholly owned or operated physician practices that are not provider-based." CMS stated that "the overhead costs associated with those services would be considered operating costs of the inpatient hospital services and, as such, included in the hospital's bill for the inpatient service." Based on this approach, CMS proposed that payment to the physician practice under Medicare's physician fee schedule be provided at a lower facility rate (exclusive of the overhead, staff, equipment and supplies needed to perform the nondiagnostic services at the physician's facility). CMS explained that the proposed payment methodology would "avoid duplicate payment for services under both the IPPS and the Medicare Physician Fee Schedule." CMS indicated that it will provide more detail on its suggested payment methodology in a subsequent physician fee schedule proposed rule.

### **The Provision Of Routine Services Under Arrangement Outside The Hospital**

Since its inception, the Medicare program has authorized hospitals to either directly furnish services or to furnish services via a subcontract with another provider or supplier, which in Medicare parlance is referred to as "under arrangement."

In the 2012 IPPS Final Rule, CMS clarified that a hospital may not furnish routine services under arrangement if the services are provided outside of the hospital. [Click Here](#) for a copy of the relevant Federal Register preamble discussion.

CMS has explained this policy as follows:

We stated that we believe that this proposal is consistent with the statute because the statutory language specifying that the routine services described in sections 1861(b)(1) and (b)(2) of the Act be provided "by the hospital" suggests that the hospital is required to exercise professional responsibility over the services, including quality controls. In situations in which certain routine services are provided through arrangement "in the hospital," for

example, contracted nursing services, we believe the arrangement generally results in the hospital exercising the same level of control over those services as the hospital does in situations in which the services are provided by the hospital's salaried employees.

Therefore, if routine services are provided in the hospital to its inpatients, we consider the service as being provided by the hospital. However, if these services are provided to its patients outside the hospital, the services are considered as being provided under arrangement, and not by the hospital. **Therefore, consistent with the statute, only therapeutic and diagnostic services can be provided under arrangement outside the hospital. We indicated that if we finalized this policy, we would change the provisions of Section 2118 of the PRM-I accordingly.** (Emphasis added.)

The basis for this policy change is the expressed concern of CMS that if two hospitals are under two different payment systems, such arrangements could result in "inappropriate and potentially excessive Medicare payments." As an example, CMS discussed the provision of ICU services under arrangement by an IPPS-excluded hospital:

Because the two hospitals in the example... are under two different payment systems, we believe this arrangement can result in inappropriate and potentially excessive Medicare payments. The IPPS-excluded hospital, hospital A, is paid on a reasonable cost basis, subject to a ceiling. In most cases, this payment is greater than if the hospital were paid under the IPPS for the same patient. Furthermore, although there is a ceiling on the amount of Medicare payment for hospital A, there are also provisions that allow hospital A to receive adjustments to its ceiling in certain circumstances, which could allow payment to hospital A above those allowed by its ceiling. Therefore, these current arrangements could allow hospital A to request an adjustment to its ceiling because its ICU costs have increased beyond what is allowed. In that case, hospital A would receive additional payments beyond its ceiling. **We believe that by limiting the furnishing of routine services under arrangements to situations in which the services are furnished in hospital A, we will reduce the opportunity for gaming.** (Emphasis added.)

### **The Determination of Hospital Pension Costs: Different Methodology For Wage Index and Cost Reporting**

CMS amended the rules for determining hospital pension costs by establishing two separate methods for purposes of the Medicare Wage Index and Medicare cost reporting for payment. For purposes of calculating a hospital's Medicare Wage Index, CMS will now apply a "rolling three-year average" of the hospital's annual pension plan contributions. For the Medicare cost reporting, a hospital's pension cost will now equal "the cash basis contribution deposits (made within the current cost reporting period and not reflected as a pension cost for a prior cost reporting period) plus any carry forward contributions, subject to a limit." CMS explains that this limit "is equal to 150 percent of the average pension contributions made during the highest three consecutive cost reporting periods out of the five most recent cost reporting periods..." For hospitals with current period contributions in excess of required limit, however, CMS will allow submission of documentation explaining why the excess contributions should be "reportable as current period pension costs."

**Action Steps**

**The Three-Day Payment Window:** Due to the long-standing compliance enforcement initiatives dating back to 1995 and continuing through the present associated with the Three-Day Payment Window, hospitals and their subsidiary physician practices are well-advised to ensure compliance with the Three-Day Payment Window as it relates to preadmission services furnished in wholly owned or operated physician practices.

**Routine Services Furnished Under Arrangement:** Hospitals must ensure that effective October 1, 2011 routine services furnished outside of the hospital are not billed as if furnished under arrangement, and that only therapeutic and diagnostic services provided outside of the hospital are billed under arrangement. Failure to comply with this requirement could expose the hospital to significant penalties.

**Hospital Pension Costs:** Hospitals must assure that the reporting of their pension costs complies with CMS's requirements. For hospitals seeking to report current pension contributions in excess of Medicare's Cost-Finding limits, the hospitals should be prepared to demonstrate that such excess contributions should be allowed as current period pension costs.

If you have questions regarding compliance with the any of provisions of the 2012 IPPS Final Rule, please contact any member of the Honigman Health Care Department.