

## CMS Issues Final IPPS Rule for 2010

### Issues:

- Implementation of MIPPA cost-based laboratory
  - Payment to Method II providers
  - CAH provider-based clinical laboratories
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**Cost-based payment for laboratory draws taken outside the walls of the CAH** – *Medicare Improvements for Patients and Providers Act of 2008* (MIPPA) provided CAHs with cost-based reimbursement for laboratory draws taken outside the CAH. The 2010 final IPPS rule adds restriction on the implementation of the new rule.

To bill laboratory services and receive cost-based reimbursement, the CAH must:

1. Register the patient as outpatient **AND**
2. (a) The patient must receive outpatient services on the same day **OR**
2. (b) The sample must be collected by a CAH employee (contracted employees count)

The first requirement to qualify is to register the patient as an outpatient of the CAH. Second, the draw must either be collected by a CAH employee or the patient must receive outpatient services on the same day.

CMS states that outpatient services include the CAH and CAH facilities that are provider-based. A provider based facility includes both provider based departments and entities as described below.

An example: if a patient was in the provider-based RHC on Monday, **any** draw taken on Monday qualifies for cost-based reimbursement (regardless of the location of the draw or who drew the sample). However, if the patient was in the local clinic or RHC not provider-based to the CAH, an employee of the CAH must collect the specimen.

CMS states the employee of a provider-based *department* qualifies, but not the employee of a provider-based *entity*.

*So what is a department verses an entity?*

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A provider-based *department* “would not function as a freestanding provider of health care services”. CMS also states that a provider based *entity* “is paid differently than an entity that is not CAH-based”. 42 CFR, §413.65 defines a provider-based *department* as one not listed in 42 CFR, §489.2. Consequently, provider-based *entities* (these employees are not considered CAH employees with regards to this rule) are:

1. Skilled nursing facilities (SNFs)
2. Home health agencies (HHAs)
3. Clinics, rehabilitation agencies, and public health agencies
4. Comprehensive outpatient rehabilitation facilities (CORFs)
5. Hospices
6. Community mental health centers (CMHCs)
7. RHCs or FQHCs

If the laboratory draw occurs in one of these areas that are not provider-based to the CAH (typically this will be local HHA, hospices, SNFs, provider-based clinics, and RHCs) then the CAH must send its laboratory personnel or other CAH employee to perform this draw.

A contracted employee counts as an employee for laboratory draws. However, if the contracted employee is also an employee of the draw’s location, then they do not count (i.e. the CAH cannot contract with a SNF nurse to conduct the draw). Furthermore, CAHs should consider laboratory services not requiring a draw (like urinalysis). To qualify for cost-based reimbursement, these should be returned the same day other outpatient services are provided.

Finally, if the draw is considered part of an all-inclusive rate (like a SNF patient during their 100 lifetime days), the draw cannot be billed. The laboratory draw must be otherwise separately billable.

CMS’ intent was to keep the CAH from becoming a reference laboratory.

We recommend hospitals communicate this to its billing department. Policies should be prepared and implemented to ensure compliance.

*Remember, if the draw occurs in a SNF, RHC, clinic, or other area not provider-based to the CAH — send a CAH employee to do the draw!*

**Payments to Method II Providers** – This proposal has passed. The proposed rule implied that Method II providers would lose the 1% outpatient add-on for **all** outpatient services. However, the final rule clarifies that CMS will issue instructions to the Medicare contractor’s FISS system to break apart those charges submitted as Method II claims and those submitted without professional fees. Accordingly, Method II providers will receive 101% of cost on all inpatient and outpatient claims not billed with professional fees.

For claims billed with outpatient technical and professional portions on the UB (those billed Method II) the payment will be an effective 112% (80% of 115%) of physician fee schedule and reasonable cost (remember: the 15 % Method II bonus does not apply to the patients’ portion).

*We recommend that Method II providers continue to request this election.* The 1% add-on will only, in rare instances, be greater than the physician fee schedule add-on.

This rule is effective for cost-report periods beginning on or after October 1, 2009.

## **CMS Issues Final IPPS Rule for 2010 (Continued)**

**Provider-based clinical laboratories** – The provider-based rules state that clinical laboratories are not required to follow the provider-based rules. The provider-based rules do not typically cover departments (or entities) paid on their own methodology regardless of the provider type owning or running them. For example, a free-standing SNF is paid the same RUG as a SNF provider-based to a PPS or CAH hospital. Initially, CMS put clinical laboratories into this category. However, clinical laboratories provider-based to a CAH are paid reasonable cost. Therefore, the final rule includes clinical laboratories as eligible for provider-based status. To be provider-based to a CAH, these facilities must meet the provider-based rules, including the new distance requirement. Clinical laboratories owned and operated by a CAH before the January 1, 2008, provider-based rule date, can be grandfathered as provider based.