Critical Access Hospital and Rural Health Clinic Conference

Provider-Based Hospital Departments – Are We Compliant?

September 14, 2017

AGENDA

- Reasons for Hospital/Clinic Integration
- History of Provider-Based Regulations
- Provider-Based Requirements
- Benefits of Attestation
- Shared Space
- Medicare Options for Physician Clinics Owned by Hospitals
- Evaluating the Benefits
- Helpful Hints
Reasons for Hospital/Clinic Integration

Provider-Based

Provider-based is a Medicare billing status and process for physician services that are provided in a hospital outpatient department.
Provider-Based

Reasons for Hospital/Clinic Integration:

• Strengthen relationships
• Diversify hospital services
• Reduce duplication of ancillary services, gain efficiencies
• Enhance public image
• Expand market share
• Utilize hospital’s credit rating
• Enhance reimbursement
• Create a unified system

History of Provider-Based Regulations
History of Provider-Based Regulations

The final rules for implementing the prospective payment system for outpatient hospital services were issued on April 7, 2000.

Previous to the publication of the provider-based requirements in the Federal Register, the provider-based concept was loosely defined and interpreted.

Various changes were made on August 3, 2000; December 21, 2000; November 30, 2001; and August 1, 2002.

In August 2002, CMS made important distinctions between the requirements for on-campus and off-campus sites.

CMS furnished further clarification of its policies in Program Memorandum A-03-030 published on April 18, 2003.

January 1, 2008 — Provider-based locations created or acquired by a CAH must be 35 miles (or 15 miles over secondary roads or mountainous terrain) from another hospital or CAH.

- The rule does not apply to provider-based RHCs

- Off-campus provider-based arrangements established prior to January 1, 2008, were grandfathered

November 2, 2015 — Bipartisan Budget Act of 2015 signed

- Section 603 impacted OPPS hospital off-campus locations

- Effective January 1, 2017
## History of Provider-Based Regulations

### December 13, 2016 — 21st Century Cures Act signed
- Provides an exception for off-campus provider-based departments that were mid-build or under development prior to November 2, 2015.
- Must meet all of the following requirements to be eligible for the full OPPS payment rate beginning January 1, 2018:
  ~ File a provider-based attestation within 60 days after the date of enactment of the Cures Act.
  ~ Submit a change to the 855A enrolling the location.
  ~ Off-campus department meets the definition of "mid-build" and submits certification within 60 days of the enactment of the Cures Act.

### CMS released “Guidance” in November 2008 regarding regulatory changes and clarification of existing provider-based regulations for CAHs
  ~ CAHs intending to open off-campus provider-based facilities must seek "an advance determination of compliance" from CMS.
  ~ CMS stated that any CAH with an off-campus provider-based facility established on or after January 1, 2008, was required to submit an attestation detailing compliance.
    - Regulation states may submit attestation.
### History of Provider-Based Regulations

- Clarification: Provider-based determinations are site-specific.
  - If a CAH relocates a grandfathered off-campus provider-based facility after January 1, 2008, the new off-campus site must comply with the distance requirements and all other provider-based rules at the new location. If the new site does not meet the requirements, it must either surrender its provider-based designation or the hospital will lose CAH status.

- Clarification: Off-campus distinct part units, psychiatric and rehab, must meet CAH distance requirements.

- If an OPPS relocates a grandfathered off-campus provider-based facility, the new site will no longer be grandfathered unless it meets specific rules – acts of God.

### History of Provider-Based Regulations

- Clarification: Termination of Medicare Provider Agreement for non-compliant provider-based locations.
  - The first time a CAH is found to be out of compliance with the distance requirements it is subject to termination of its Medicare provider agreement.
  
  - The offending CAH would have 90 days to prove to CMS the determination was incorrect or convert the provider-based clinic to a freestanding clinic.
  
  - Alternative: The CAH would need to apply for Medicare certification as an acute-care hospital and receive reimbursement under the DRG payment system.
History of Provider-Based Regulations

Bipartisan Budget Act of 2015

As of January 1, 2017, PPS hospitals are no longer able to receive full OPPS payments for any facility that had not billed provider-based prior to November 2, 2015, unless they become excepted under the Cures Act.

- The law does not affect on-campus hospital departments.
- Critical Access Hospitals (CAHs) are excluded from the amendment to the law.

January 1, 2017 — Billing

- Professional billing:
  - POS 19 — "Off Campus – Outpatient Hospital"
  - POS 22 — "On Campus – Outpatient Hospital"

- Technical (facility) billing:
  - "PO" modifier for all excepted off-campus provider-based outpatient department services. 100% OPPS rate. Does not apply to Critical Access Hospitals.
  - "PN" modifier for all non-excepted services on the facility bill in off-campus provider-based outpatient departments. 50% OPPS rate. Does not apply to Critical Access Hospitals.
History of Provider-Based Regulations

- Bipartisan Budget Act of 2015
  - Rural Health Clinics (RHCs) that are owned and operated by hospitals are excluded from the amendment to the law because they are not departments of a hospital, rather they are provider-based entities due to their separate enrollment and certification process. In addition, RHCs are not paid under OPPS. Therefore, hospitals should be able to establish new off-campus provider-based RHCs on or after November 2, 2015.
  - However, for provider-based RHCs that are established after November 2, 2015, there is some question as to how the off-campus payment for non-RHC services will be paid.

History of Provider-Based Regulations

Regulation References:

- 42 CFR 482 (Hospital CoP)
- 42 CFR 488 Subpart A (Accreditation & Survey Rules)
- 42 CFR 489 (Provider Agreement)
- 42 CFR 413.65 (Provider-based)
  - Transmittal A-03-030 (Sample Attestation)
  - 42 CFR 485.610(e)(2) (CAH Distance Requirements)
- Section 148 of MIPPA (CAH Lab - effective July 1, 2009)
- CMS 2017 OPPS rules (effective January 1, 2017)
Provider-Based Requirements:

1. Distance requirement
2. Operate under the same license as the main provider (unless otherwise required by State law)
3. Clinical integration
   - Integrated medical staff
   - Integrated medical records
   - Quality monitoring
Requirements

Provider-Based Requirements (Continued):

4. Public awareness
   - Signage
   - Name badges
   - Advertising
   - Patient bills
   - Registration forms
   - Telephone

5. Ownership
   - If the department is off-campus, it must be 100% owned by the provider
   - If it is on-campus and a joint venture, it must be on the campus of the billing facility

6. Control
   - Same governing body
   - Common bylaws
   - Main provider’s governing body has final approval over administrative decisions, contracts, and personnel matters
Requirements

Provider-Based Requirements (Continued):

7. Administration and supervision
   - Same supervision as any other department
   - Reporting relationship
   - Professional staff must have hospital privileges

8. Financial integration
   - Must be included in hospital trial balance
   - Must be included in the allowable cost centers on Medicare cost report, same as any other hospital department

9. Provider must employ all non-management staff who provide patient care. Clinic management and providers who are paid by Medicare under a fee schedule may be contracted

10. Medicare patients must be registered as hospital patients

11. Non-discrimination provisions apply to providers

12. EMTALA obligations
   - On campus – apply as part of hospital
   - Off campus – apply if held out as Urgent Care or > 1/3 patient visits are unscheduled
**Requirements**

**Provider-Based Requirements (Continued):**

13. Inpatient of hospital – 3-day payment window applies to all facility components for services in the provider-based entity AND all diagnostic and related therapeutic professional components

14. Off-campus sites must provide notice of dual co-insurance to each Medicare patient before service is provided (unless emergent service)

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**Benefits of Attestation**
Benefits of Attestation

Benefits of submitting an attestation:

- An attestation is a voluntary signed statement by the provider stating it meets all required provider-based criteria
- Triggers self-review of criteria
- Provides written support of compliant process
- Educates staff on requirements
- CMS recoups excess payment, if provider is found to be non-compliant. If CMS accepts the attestation following the review, it will limit recoupment if the facility is later determined to be out of compliance. Without a reviewed attestation on file, CMS can recoup as far back as the applicable statute of limitations allows.

Shared Space
Shared Space

CMS regional offices are increasingly restrictive in their review and approval of shared space/mixed-use sites.

• Mixed-Use Sites: Provider-based vs. Freestanding
  − No formal guidance in regulations or otherwise
  − Only CMS enforcement practice: learned through attestations and discussion with CMS representatives

• CMS requiring more separation of the freestanding vs. provider-based space (However, not necessarily including Rural Health Clinics – discussed later)

• CMS recently trained accrediting organizations, such as the Joint Commission, on shared-space arrangements in provider-based settings

Shared Space

What will CMS be looking for when reviewing?

• All certified hospital space, departments, services, and/or locations:
  − Must be under hospital’s control 24/7
  − Cannot be “part-time” with the hospital and “part-time” with another hospital, ASC, physician office, or any other activity
  − Required to be “the hospital” 24/7, however, outpatient departments are not required to be open for business 24/7
Shared Space

What will CMS be looking for when reviewing (Continued)?

- Features such as:
  - Shared entry ways
  - Interior hallways
  - Treatment rooms
  - Waiting rooms
  - Registration

What will CMS be looking for when reviewing (Continued)?

- Building plans that do not clearly define hospital space as a distinct space are an indicator of mixed-use

- CMS enforcement position appears to be based on:
  - State Operations Manual § 2026 and the CoP requirement that a hospital or a department be a "singular unit" dedicated in its entirety to hospital purposes and the treatment of hospital patients
  - Public awareness requirement
Medicare Options for Physician Clinics Owned by Hospitals

- Physician Office
  - “Freestanding” from a billing, not location, standpoint
- Hospital or Critical Access Hospital Outpatient Department (HOPD)
  - Synonymous with Provider-Based Clinic/Department
  - Billing and payment similar to emergency room visit
- Rural Health Clinic (RHC)
  - Freestanding
  - Hospital-Based RHC (Provider-based “entity,” not department)
## Medicare Options For Physician Clinics

### Medicare Reimbursement Options for Physician Services

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Free-Standing Clinic</th>
<th>Free-Standing RHC</th>
<th>Provider-based Clinic</th>
<th>Provider-based RHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Hospital &lt; 50 beds</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>E</td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td>A</td>
<td>B</td>
<td>D</td>
<td>E</td>
</tr>
<tr>
<td>Hospital &gt; 50 beds</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>B</td>
</tr>
</tbody>
</table>

- **A**: Global clinic reimbursement on Medicare physician fee schedule.
- **B**: Cost-based reimbursement for all RHC services, professional and facility combined; subject to Medicare maximum limit per encounter.
- **C**: Medicare physician fee schedule payment for professional services, reduced for hospital site-of-service; APC payment for facility component.
- **D**: Medicare physician fee schedule payment for professional services, reduced for hospital site-of-service; cost-based CAH payment for facility component.
- **E**: Cost-based reimbursement for all RHC services, professional and facility combined; not subject to Medicare maximum limit per encounter, i.e., full cost reimbursement.

## Medicare Options For Physician Clinics

**Physician Office (i.e., Freestanding Clinic)**

- Enroll location(s) under 855B Supplier #
- Bill on Form 1500 with Supplier # and Physician NPI
  - POS Code 11 (physician office) – Global
    - Facility/technical component (TC) and
    - Professional component (PC)
- Paid by CPT code – Medicare Physician Fee Schedule (PFS)
- No Entity Level Conditions of Participation (COPs)
- No Medicare co-location (mixed-use) restrictions
- Only compliance issue is Stark laws (if leasing to physician owned group)
Medicare Options For Physician Clinics

Hospital Outpatient Department (includes CAH)

- Enroll location(s) Enrollment for Site
  - For TC on 855A under Hospital Provider #
  - For PC on 855B under Group Clinic # or CAH Provider
  - Form 855R if physicians reassign Part B# (of Hospital) or to CAH Provider # if Method II

- Split Billing
  - TC on UB-04 Hospital Provider # as O/P Service (APCs/Cost)
  - PC on 1500 (POS code 19/22) – Paid on fee schedule; or
  - ~ If Method II in CAH O/P departments on UB-04, paid on fee schedule +15% (on Medicare payment portion only)

Medicare Options For Physician Clinics

Hospital Outpatient Department (includes CAH) (Continued)

- Site must meet provider-based requirements
- Site subject to all Hospital COPs previously discussed:
  - CMS's exclusive use interpretation – 24/7/365 for hospital
  - AND, physically segregated from any other provider or supplier operations
### Medicare Options For Physician Clinics

#### Freestanding Rural Health Clinic (RHC)
- Enroll under 855A as RHC
  - Covers TC & PC for Physician & midlevel service E&M
  - Surveyed – Based on RHC COPs by:
    - Medicare through state DHS, or
    - Accrediting body for deemed status
- Bill for RHC services on UB-04 – Global payment at cost subject to per visit limit (2016 RHC cap is $81.32)
- Bill for ancillary services under Part B clinic supplier #
  - Paid at fee schedule by CPT code
  - Co-location of other provider-types allowed for RHC status

#### Provider-Based RHC
- Same RHC COPs as Freestanding RHC
- Must meet most of same provider-based requirements as HOPD
  - Exempt from: 35 mile distance test, public awareness, split billing notice
- If provider-based to <50 bed Hospital, then exempt from the RHC cap
  - Provider-based RHCs often greater than $200 per encounter
  - Bill ancillaries under Hospital Provider #
- **Caution!** CMS Regional Offices differ on application of off-campus provider-based requirements/restrictions and CAH location test related to services billed as Hospital services (i.e., the non-RHC services, like lab and technical component of other diagnostic test)
Evaluating the Benefits

Provider-Based Clinics

Evaluating Benefits vs. Costs of Converting to Provider-Based Clinic Status

Financial Analysis
- Reimbursement impact
- Conversion costs

Physician Relations
- Employed versus contract physicians
- Productivity measures

Strategic Objectives
- Internal politics
- Community relations/perceptions
- Competition
Helpful Hints

- Evaluate your provider-based facilities – Internally audit for compliance with ALL provider-based requirements
- Consider whether your use of space has CHANGED since your originally attested to/claimed provider-based status
- Evaluate each freestanding clinic to which you lease space and how it interacts with your provider-based facilities – keep them separate!
- Ensure billing is properly identified and using the proper modifier(s) and POS code
- For facilities that may no longer meet provider-based criteria, remember that the hospital’s ability to take advantage of 340B drug pricing is affected
Questions?

Thank you!
Today’s Presenter:

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