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DISCOVERY HEALTHCARE
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Provider-Based Determinations

Winter is Coming!

OBJECTIVES

- Overview of Provider Based rules and regulations
- Importance of On Campus vs Off Campus
- Better understanding of the MAC and CMS Regional Office(s) review of the process
- HHS Office of Inspector General (OIG) June 2016 Report on Provider Based determinations
- FY 2017 OPPS Updates; Off Campus payments

Medicare's Provider-Based (PB) Regulations And Requirements

MEDICARE'S PROVIDER-BASED REGULATIONS

- Scope of Regulation:
  - It applies to all facilities for which provider-based status is requested, inclusive of satellite/remote locations of a hospital / facility.
  - While the applicable regulations applicable and enforceable by Medicare, the filing of the PB attestation is voluntary.
  - On campus means the buildings/structures in and immediately adjacent to such buildings that are located within 250 yards of the main hospital.
    - Risks: CMS Regional Offices use different methodology in assessing the meaning of within 250 yards. Reach out to your MAC to see how it defines "within 250 yards."

Per 42 CFR § 413.65(a)

DEFINITIONS & TERMINOLOGY

- Provider-based status

  - The relationship between a main provider (e.g. hospital) and one or more of the following:
    - a department of a provider,
    - remote location of a hospital,
    - satellite facility, and/or
    - a provider-based entity (e.g. RHC).

DEFINITIONS & TERMINOLOGY

- Main provider
  - The main hospital location.
  - Main provider either creates or acquires ownership of another entity to deliver additional health care services under its name, ownership, and financial and administrative control.
  - CMS-855A is completed by the main provider (hospital).

FACILITY LOCATION

- Distinguishing between
  - “within four walls of the hospital”,
  - “on campus” and
  - “off campus”.

FACILITY LOCATION

- "Within four walls of the hospital" considerations
  - Generally, however there are exceptions depending on the facts and circumstances of the situation, CMS does not concern itself with provider-based determinations if the facility is "within the four walls of the main hospital building".
  - It is not always easy to distinguish what is within the main hospital building versus what is outside the main building.

FACILITY LOCATION

On Campus Definition

- The physical area immediately adjacent to the provider's main building,
- Other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main building, and
- Any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

What about a multi-campus facility?

FACILITY LOCATION

- Off campus
  - Not “within four walls of the main hospital building”
  - Not “on campus”
  - More than 250 yards from the main hospital building but within 35 miles of the main provider’ s campus, or
  - Meets one of the other off-campus location criteria.

MEDICARE'S PROVIDER-BASED REGULATIONS

- Benefits of Submitting a Provider-Based Attestation:
  - If a provider does not submit a PB Attestation and CMS later determines that the related PB facility does not meet the requirements for being Provider Based, CMS can and will recover the difference between the payment made and the estimated payments that should have been made for services at this applicable facility going to all open and re-openable reporting periods with interest based upon the time value of money.
  - Where the provider submits a PB Attestation and begins billing the applicable facility services as provider-based, any subsequent denial of PB status is limited to retroactive recovery back to the date of the submission of the PB Attestation to the MAC.
  - Although voluntary, it is strongly suggested that a hospital consider completing a Medicare Provider-Based Status Attestation Statement to ensure CMS agrees with your PB determination and to reduce future compliance risks.

Per 42 CFR § 413.65(j)(1)(ii)

MEDICARE'S PROVIDER-BASED REGULATIONS

Provider-based determinations are not applicable for the following facilities:

- ASCs, CORFs, HHAs, SNFs, Hospices,
- Inpatient rehabilitation units excluded from hospital inpatient PPS,
- IDTFs,
- Screening mammography centers,
- Facilities that furnish only clinical diagnostic laboratory tests, other than those clinical diagnostic laboratories operating as parts of critical access hospitals (CAHs) on or after October 1, 2010,
- End-Stage Renal Disease (ESRD) facilities (determinations made under 42 CFR § 413.174),
- Departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid,
- Ambulances,
- Rural health clinics (RHCs) affiliated with hospitals having **50 or more beds**

FREE-STANDING VS PROVIDER-BASED

- No difference in the Medicare certification/accreditation process for free-standing versus PB facilities, but reimbursement differences will exist.

- Facilities desiring to be PB will need to meet all applicable Medicare PB regulatory requirements set forth in *42 CFR § 413.65*.

- There determination of a Free-Standing vs PB entity hinges on the integration of the entity into the main hospital/facility.

INTEGRATION OF ENTITY FOR PB

- Department of a provider
  - A facility or organization that is either created by or acquired by the main provider.
  - The health care services provided in the facility would be the same type as those furnished by the main provider.
  - Services provided under the name, ownership, and financial and administrative control of the main provider. A department of a provider comprises both the specific physical facility that—
    - serves as the site where services are performed, and
    - the personnel and equipment needed to deliver the services at that facility.
  - A department of a provider may not by itself be qualified to participate in Medicare as a provider under 42 CFR § 489.2, and is subject to the Medicare conditions of participation of the main provider (e.g. hospital).
    - e.g.; O/P Surgery Centers (not ASCs), O/P Radiology Centers (not IDTFs), Physician clinics (not RHCs, FQHCs, or clinic locations billed with POS code 11, office)

INTEGRATION OF ENTITY FOR PB

- Department of a provider
  - Bills under the main provider's (e.g. hospital's) Medicare provider number.
  - Physical location(s) are disclosed on main provider's (e.g. hospital's) CMS-855A.
  - If the physical location was previously disclosed on the CMS-855B as a clinic/group practice, the practice location needs to be updated on the CMS-855B to reflect it is now a hospital location and the place of service (POS) code for the CMS-1500 claim form needs to change from POS 11 (office) to POS 22 (hospital outpatient).

INTEGRATION OF ENTITY FOR PB

- Remote location of a hospital
  - A facility or an organization that is either created by or acquired by a hospital.
  - The remote location furnishes inpatient hospital services under the name, ownership, and financial and administrative control of the main provider.
  - A remote location of a hospital comprises both—
    - the specific physical facility that serves as the site where services are performed, and
    - the personnel and equipment needed to deliver the services at that facility.
  - A remote location is subject to the Medicare conditions of participation of the hospital (the main provider).

INTEGRATION OF ENTITY FOR PB

- Remote location of a hospital
  - Bills under the main provider's (e.g. hospital's) Medicare provider number.
  - Physical location(s) are disclosed on main provider's (e.g. hospital's) CMS-855A.
  - The remote location no longer has its own separate Medicare enrollment, provider number, or CMS-855A.

INTEGRATION OF ENTITY FOR PB

- Satellite facility
  - A part of a hospital or a hospital unit that—
    - provides services in a building also used by another hospital, or
    - in one or more buildings on the same campus as buildings also used by another hospital.
  - A satellite facility always involves co-location with another hospital. Bills under the main provider' s (e.g. hospital' s) Medicare provider number.
  - Physical location(s) are disclosed on main provider' s (e.g. hospital's) CMS-855A.
  - The satellite facility no longer has its own separate Medicare enrollment, provider number, or CMS-855A.

Multi-Campus?

INTEGRATION OF ENTITY FOR PB

- Provider-based entity

  - The majority tend to be RHCs, but there could also be some other provider of health care services that is either created by or acquired by a hospital (main provider).
  - The health care services provided in the facility are of a different type from those of the hospital (main provider).
  - Services are provided under the ownership and administrative and financial control of the hospital (main provider).

INTEGRATION OF ENTITY FOR PB

- Provider-based entity
  - A provider-based entity comprises both—
    - the specific physical facility where services are performed, and
    - the personnel and equipment needed to deliver the services at that facility.
  - A provider-based entity may, by itself, be qualified to participate in Medicare as a provider under 42 CFR § 489.2.
  - The Medicare conditions of participation for the provider-based entity must be satisfied.

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Licensure
- Clinical services
- Financial integration
- Public awareness
- Obligations of hospital outpatient departments and hospital-based entities

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Licensure
  - The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license.
    - Except in areas where the State requires a separate license for the facility, or
    - in States where State law does not permit licensure of the provider and the prospective facility under a single license.
  - The above does not apply to provider-based entities such as RHCs. Licensure should be site specific

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Clinical services
  - The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:
    - Professional staff of the facility or organization have clinical privileges at the main provider.
  - The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Clinical Services
  - The Medical Director of the facility seeking provider-based status maintains a reporting relationship with the Chief Medical Officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists all other units within the main provider.

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Clinical Services
  - Medical Staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including QA, UR, and the coordination and integration of services.
  - Medical Records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Clinical Services
  - Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Financial integration

- The financial operations of the facility or organization are fully integrated within the financial system of the main provider, (shared income and expenses).

  - The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider’ s trial balance.

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Public awareness
  - The facility or organization seeking status as a department of a provider, a remote location of a hospital, or satellite facility is held out to the public and other payers as part of the main provider. (excludes RHCs)
  - There must be clear awareness by the patient that he/she is entering a unit of the hospital.
    - The name of the location should include the name of the hospital.
    - All site specific identifying information should include the name of the hospital and match the location name(s) disclosed in the CMS-855A including licensure (if any), CLIA, etc.
    - Includes, but is not limited to, Signs, Websites, Letterhead, Fax cover sheets, Registration forms, Billing forms, Phone Book information, advertisements, name tags and clothing, how the phone is answered, business cards, logos, etc.

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Obligations of hospital outpatient departments and hospital-based entities
  - The following departments must comply with the antidumping rules:
    - Any facility or organization that is located on the main hospital campus and is treated by Medicare as a department of the hospital; and
    - Any facility or organization that is located off the main hospital campus that is treated by Medicare as a department of the hospital and is a dedicated emergency department, as defined in 42 CFR § 489.24(b).
    - If emergency services are provided at the hospital but are not provided at one or more off-campus departments of the hospital, the governing body of the hospital must assure that the medical staff has written policies and procedures in effect with respect to the off-campus department(s) for appraisal of emergencies and referral when appropriate.

PROVIDER-BASED REQUIREMENTS APPLICABLE TO ALL PROVIDER-BASED FACILITIES

- Obligations of hospital outpatient departments and hospital-based entities
  - Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service (practitioner should not bill the office place of service (POS) code "11", but appropriate hospital POS code).
    - CMS has stated that physicians (or those to whom they assign their billing privileges) are responsible for appropriate billing, but note that physicians who practice in hospitals, including off-site hospital departments, do so under privileges granted by the hospital. Thus, CMS believes the hospital has a role in ensuring proper billing.

ADDITIONAL PROVIDER-BASED REQUIREMENTS FOR OFF CAMPUS FACILITIES ONLY

- Operation under the ownership and control of the main provider
  - The business enterprise that constitutes the facility or organization is 100 percent owned by the main provider.
  - The main provider and the facility or organization seeking status as a department of the main provider, a remote location of a hospital, or a satellite facility have the same governing body.
  - The facility is operated under the same organizational documents as the main provider (e.g., common bylaws and operating decisions of the governing body).
    - Common control of two separate entities by the same parent organization is not sufficient (a traditional position of CMS).

ADDITIONAL PROVIDER-BASED REQUIREMENTS FOR OFF CAMPUS FACILITIES ONLY

- Operation under the ownership and control of the main provider

➢ The main provider has final responsibility for:

- administrative decisions,
- final approval for contracts with outside parties,
- final approval for personnel actions,
- final responsibility for personnel policies (such as fringe benefits or code of conduct), and
- final approval for medical staff appointments in the facility or organization.

ADDITIONAL PROVIDER-BASED REQUIREMENTS FOR OFF CAMPUS FACILITIES ONLY

- Administration and supervision
  - The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:
    - The facility or organization is under the direct supervision of the main provider.
  - The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability.

ADDITIONAL PROVIDER-BASED REQUIREMENTS FOR OFF CAMPUS FACILITIES ONLY

- Administration and Supervision
  - The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services.

  - Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are –
    - Contracted out under the same contract agreement; or
    - Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

ADDITIONAL PROVIDER-BASED REQUIREMENTS FOR OFF CAMPUS FACILITIES ONLY

- Location
  - The facility or organization meets one of the following requirements:
    - The facility or organization is located within a 35-mile radius of the campus of the hospital or CAH that is the potential main provider.
      - Note: The 35-mile radius is measured by actual straight-line distance between the provider and the facility, not road miles.
    - The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment greater than 11.75% and meets other specified requirements

One would expect the 250-yard requirement should be measured in the same way?

ADDITIONAL PROVIDER-BASED REQUIREMENTS FOR OFF CAMPUS FACILITIES ONLY

- Location
  - The facility/organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by satisfying one of the 75% tests.
  - Meets criteria for neonatal intensive care type units
  - An RHC that is otherwise qualified as a provider-based entity of a hospital that has fewer than 50 beds and is located in a rural area.

ADDITIONAL PROVIDER-BASED REQUIREMENTS FOR OFF CAMPUS FACILITIES ONLY

- Location
  - A facility or organization may qualify for provider-based status only if the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

ADDITIONAL PROVIDER-BASED REQUIREMENTS FOR OFF CAMPUS FACILITIES ONLY

- Additional obligations of off-campus hospital outpatient departments and hospital-based entities.
  - When a Medicare beneficiary is treated in a hospital outpatient department that is not located on the main providers' campus, the treatment is not required to be provided by the antidumping rules, and the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician services, the following requirements must be met:
  - The hospital must provide written notice to the beneficiary, before the delivery of services, of –
    - The amount of the beneficiary's potential financial liability; or
    - If the exact type and extent of care needed are not known:
      - An explanation that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based, an estimate based on typical or average charges for visits to the facility and a statement that the patient's actual liability will depend upon the actual services furnished by the hospital.

ADDITIONAL PROVIDER-BASED REQUIREMENTS FOR OFF CAMPUS FACILITIES ONLY

- Additional obligations of off-campus hospital outpatient departments and hospital-based entities

  - In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules, notice must be given as soon as possible after the existence of any emergency has been ruled out or the emergency condition has been stabilized.

  - Although patient signatures are not required on the notices, it would be a good practice to follow.

OTHER PROVIDER-BASED CONSIDERATIONS

- Joint Ventures
  - Only when on-campus of the main provider it will be provider-based to
- Management Contracts
  - Not applicable to on-campus provider-based locations.
  - Common employment of staff at the main provider and at the provider-based facility who are directly involved in the delivery of patient care.
  - This does not include the management staff and staff who furnish patient care services of a type that would be paid for under a Medicare fee schedule.
  - Many other considerations

WHAT HAPPENS TO A PB SUBMISSION?

- Novitas backlog of PB Reviews
  - With the Transition of AB MAC Jurisdiction H from TrailBlazer to Novitas Solutions, there were approximately 180 outstanding Provider Based Attestations (PBA).
  - As of February 28, 2015, this number was essentially unchanged.
    - CMS implemented a new standard to "grade" the MACs on timeliness of the completion of their PBAs, effective 3/1/2015. As a consequence Novitas then pivoted to a Last In-First Out review process to maintain timeliness (the old ones had already failed the standard.
  - Novitas will eventually get caught up but it will take some time.

WHAT HAPPENS TO A PB SUBMISSION?

- Novitas Review of the PBA
  - The MAC works with the CMS Regional Office (RO) in the completion of the PBA review.
  - The Dallas and Denver CMS RO(s) worked to together to develop a review program that both require to be completed by ALL MACs submitting PBA determinations.
  - There are several items that the RO's focus on: (most critical)
    - Current copy of State License,
    - Support for financial, administrative and Medical Records integration into the main hospital/facility,
    - Photographic support of signage that connects the off-campus clinic to main facility as owner/operator,
    - Support of a notification to the beneficiary of the estimate of deductible/copay.

WHAT HAPPENS TO A PB SUBMISSION?

- MACs review of the PBA
  - The MAC completes its review and makes its recommendation to the RO (rarely is it recommending to deny the PBA).
  - The RO(s) will review and request support from the MAC and make its final determination.
    - The Dallas RO approves the PBAs reviewed at 95%[1]
    - The Denver RO approves the PBAs reviewed at 96%[1]
    - Surprisingly, the Philadelphia RO's approval rate is 21%[1]

[1] *OIG Report (June 2016) OE1-04-12-0380, Appendix E*

GAME CHANGER – OFFICE OF INSPECTOR GENERAL REPORT ON PROVIDER-BASED

- OIG Report (June 2016) findings.
  - 50% of all hospitals tested had at least one PB facility.
  - With a voluntary rule, many hospitals were found to have not completed a PBA.
  - 75% of hospitals reviewed that did NOT complete a PBA for an off-campus facility were found to not even meet one single PB requirement for an off-campus location.
  - CMS does not have any sentinel review/audit process in place by off-campus PB departments.
  - Those facilities reviewed that did submit a PB did not maintain records to support their attestation.

GAME CHANGER – OFFICE OF INSPECTOR GENERAL REPORT ON PROVIDER-BASED

- OIG Report (June 2016) recommendations.
  - Require submission of PBA for ALL based facilities, regardless of location designation.
  - There is no current supported evidence that benefits of services provided by off-campus facilities support additional costs being borne by both Medicare and its beneficiaries.
  - Recommend that those hospitals tested that were found by OIG to not meet the PBA requirements.
  - Recommend CMS to either eliminate the PB designation or drop the add-on for facility costs to the payment rate.
  - Additionally, it recommends that CMS implement a system to monitor billing at all PB locations and provide increased oversight of CMS ROs and MACs to ensure that they are correctly applying the PB requirements.

GAME CHANGER – OFFICE OF INSPECTOR GENERAL REPORT ON PROVIDER-BASED

- OIG Report (June 2016) CMS response to recommendations.
  - While CMS disagreed to require submission of PBA for ALL based facilities for main campus PB entities, CMS felt that it has taken steps to address the financial impact with amendments made by section 603 of the Bipartisan Budget Act of 2015. This section requires certain off-campus PB entities to be paid under the OPPS rate effective for services on or after 1/1/2017.
  - CMS disagreed with implementing a system to monitor billing at all PB locations and provide increased oversight of CMS ROs and MACs, reasoning that it would not be "prudent to focus our (CMS) resources" related to the PB.
  - CMS agrees that it will work with the MACs to ensure that those PB entities that were missing documentation necessary to support their PB status and those that do not meet the requirements will have their overpayments recovered and revise applicable providers' OPPS rates to a free-standing entity rate as needed.

CMS ACTIONS TAKEN TO CONTROL PROVIDER-BASED PAYMENTS

- Effective 01/01/2017, payments will be made entirely on the Medicare Physicians Fee Schedule (MPFS) and NOT on OPPS for all services provided at Off-Campus PB locations, except for the following;
  - Services in a dedicated ER Department (see CMS' definition on next slide);
  - Services furnished and billed by an off campus PB department prior to November 2, 2015 (assuming that that further review doesn't deny the PB determination noted previously);
  - Services furnished in a hospital department within 250 yards (not clarified) of a remote hospital location;
  - **New services** provided on an **existing** off campus PB entity after November 2, 2015 will be paid on the fee schedule;
  - Existing off campus PB entities relocated after November 2, 2015 would loose exemption status noted above;
  - Change of Ownership (CHOW) where the new owner accepts existing provider agreement (assignment) will be allowed to maintain OPPS payment status.

CMS ACTIONS TAKEN TO CONTROL PROVIDER-BASED PAYMENTS

- **Per CMS.gov, Dedicated Emergency Department definition:**

"The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with emergency departments to provide a medical screening examination to any individual who comes to the emergency department and requests such an examination, and prohibits hospitals with emergency departments from refusing to examine or treat individuals with an emergency medical condition. The term "hospital" includes critical access hospitals.

The provisions of EMTALA apply to all individuals (not just Medicare beneficiaries) who attempt to gain access to a hospital for emergency care. The regulations define "hospital with an emergency department" to mean a hospital with a dedicated emergency department.

In turn, the regulation defines "dedicated emergency department" as any department or facility of the hospital that either –

(1) is licensed by the state as an emergency department;

(2) held out to the public as providing treatment for emergency medical conditions; or

(3) on one-third of the visits to the department in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis."


time for questions

Thank You. Have a great day!

Please call or email with any questions

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DISCOVERY HEALTHCARE

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