Compliance Risks for Provider-Based and Other Hospital-Based Provider Services

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Provider-Based: What Is It?

- Medicare rule related to payment for hospital services
 "Provider based clinics"
 - "Provider based climes"
 "Provider based billing"

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- Key concept: THIS IS JUST HOSPITAL BILLING
 - Facility fee on a CMS-1450/UB-04
 - Professional fee on CMS 1500 with POS 21, 22 (unless CAH elects all-inclusive)
 - Just like traditional hospital-based doctors in ER, radiology, anesthesiology, etc...
 - Provider-based status is NOT a special payment status except for certain RHCs
 - Hospital CoPs and payment rules apply (ex. supervision)

Provider-Based: The Rule

- Regulation 42 C.F.R. § 413.65 defines what operations are part of a Medicare certified <u>provider</u> (vs. supplier)
- It determines what services can be billed under the Medicare <u>provider</u> number (CCN)
- <u>Provider</u> = hospital, CAH, SNF, HHA, Hospice, CORFs, RHC, FQHC, CMHC
- Originally § 413.65 applied to ALL providers, but was amended in 2002 to effectively limit to hospitals/CAHs
- Sub-regulatory guidance: Program Transmittal A-03-030
 from April 2003

Provider-Based: Requirements

- Universal requirements all facilities or organizations:
 <u>Common licensure</u> if allowed by state law
 - <u>Financial Integration</u> must be included in hospital trial balance and allowable cost centers on cost report, same as any other hospital department
 - Clinical Integration -

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- Same clinical oversight as any hospital department: Medical director, QA, UR, etc.
- Medical records unified retrieval system or cross reference
- Medical staff of site/facility have clinical privileges at hospital
- <u>Public Awareness</u> patients must be aware when they enter facility that they are being treated as hospital patients
 signage, registration forms, phone listings, internet, marketing materials, etc must all use hospital name

Provider-Based: Requirements

- OFF-CAMPUS sites must also meet:
 - <u>Common ownership</u> same legal entity & governing body
 Administration and supportision -
 - Administration and supervision
 - same supervision as any other provider departmentHR, billing, payroll, benefits, records, purchasing, salary structure
 - done by same employees - Location - within 35 miles of main provider or meet market share
- test

 Management contract rules apply
- Joint venture prohibited

Provider-Based: Requirements

- Required management contract terms OFF-CAMPUS SITES:
 - provider's control is clear
 - provider employs all non-management employees providing patient care (excluding those that can separately bill – physicians, mid-level practitioners)
 - management personnel must follow provider policies
 - manager's policies must be approved by provider
 - periodic written reports required
 - on-site personnel subject to provider's approval

Provider-Based: Hospital Department Obligations

- Site of service indicator- professional component must be billed at facility payment rate (POS 22)
- All terms of provider agreement deficiencies at any site jeopardize entire hospital provider status
- Non-discrimination provisions applicable to physicians
- EMTALA obligations
 - On-campus apply as part of hospital
 - Off-campus apply only if is a dedicated ED

Provider-Based: Hospital Department Obligations

- Treat all Medicare patients as hospital outpatients (facility fee billed on UB-04/1500 with POS 22)
- DRG 3-day payment window applies
- Off-campus sites must provide notice of dual coinsurance (facility/technical & professional components) to each Medicare patient before services provided (unless emergent)
- Meet all applicable Medicare hospital conditions of participation
 - consider hospital building code

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Provider-Based: Requirements

- A facility or organization cannot be provider-based if all patient care services are furnished <u>under arrangement</u>
 - "Facility" and "organization" not defined used in definition of department
 - UA defined elsewhere as any contract that prohibits "vendor" from billing Medicare directly

Provider-Based: Requirements

• Joint Venture Rules

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- ON-CAMPUS provider-based joint venture allowed if:
 - On campus of provider/owner
 - · Can be PB to that owner only
 - No minimum ownership % required
 - · Meets universal requirements and obligations (when applicable)
- Complicated conundrum:
- Bill by hospital on UB-04, but belongs to JV
- Requires UA type contract terms
- OFF-CAMPUS site cannot be provider based if operated by a joint venture

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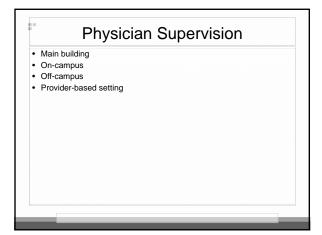
Provider-Based: On The Radar

- Recent CMS Focus
 - Narrow interpretation; shared or mixed use space
- Recent OIG Focus
 - Work Plan issue, provider survey, data collection
- OPPS Payment Changes and MedPAC
 - Recommendations
 - Collapsed 5 levels of visit codes to 1
 - Proposal to reduce payment for services in 66 APCs closer to MPFS
- Billing Modifier for CY 2016 UB and 1500

Provider-Based: Compliance Risks

• FAILURE TO INTEGRATE WITH HOSPITAL

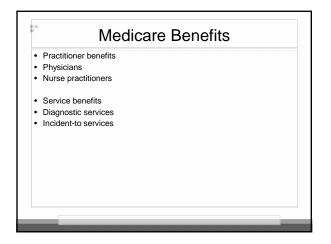
- One Rule, Multiple Requirements (Objective vs. Subjective)
 - Evidence to demonstrate entitled to hospital payment (integration with main provider)
 - Benefits of attestation process
- Billing Compliance (UB and 1500)
 - 3 Day Window Rule
 - Correct POS code for pro fees
 - Shared/split visits but no incident to pro fees
- Lack of Public Awareness
- Co-insurance notice, appropriate messaging · Conditions of Payment (ex. supervision)

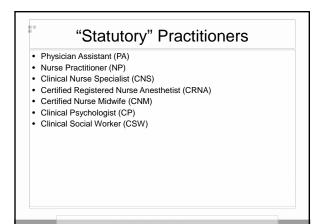


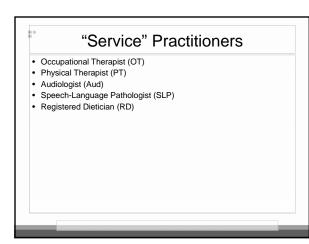


- Diagnostic tests
- Supervising physician must be clinically able
- Direct supervision requires immediate availability, not physical presence
- Except direct supervision means office suite for non-hospital setting performing tests under arrangement

Therapeutic Services Supervising non-physician practitioner permitted Supervisor must be clinically able General supervision permitted for list of services Direct supervision requires immediate availability, not physical presence







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Physician Involvement

- State physician supervision requirements PA, CRNA, CNM, PT,
- OT, SLP, Aud, RD
 State collaboration requirements NP, CNS • Written agreement to consult with attending physician - CP, CSW

Reimbursement

• 100% of Medicare Physician Fee Schedule (MPFS) – PT, OT, SLP, Aud, CP, CRNA, CNM

- 85% of MPFS PA, NP, CNS, RD
- 75% of MPFS CSW
- 50% of MPFS medically directed CRNA
- 16% of MPFS Assistant at surgery

Shared / Split Visit

- Mid-level practitioner performs all three components of Evaluation & Management service
- Physician conducts and documents face-to-face encounter same day
- Same employer
- Physician may bill
- · Medicare Manual vs. Local Coverage Determinations

Incident To Service

- Initial professional service permits subsequent incidental services performed by auxiliary personnel under direct supervision in nonhospital setting
- All "statutory" practitioners (except CSW) also may bill for "incident to" services
- Mid-level practitioners not required to enroll in Medicare

Scope of Practice State laws subject to Medicare coverage rules Supervision of diagnostic testing

- Therapeutic services of audiologist
- Pharmacist services

Hospital Employer

- Billable professional services
- Non-billable quality assurance or administrative services
- Meaningful Use Program
- · Inpatient rounds subject to global surgery package
- Hospital-employed mid-level practitioners leased to community
 physician group practices

