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 billing"
- **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 provider (vs. supplier)
- It determines what services can be billed under the Medicare provider number (CCN)
- Provider = 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:
  - Common licensure - if allowed by state law
  - Financial Integration – must be included in hospital trial balance and allowable cost centers on cost report, same as any other hospital department
  - Clinical Integration –
    - 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
  - Public Awareness – 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:
  - Common ownership - same legal entity & governing body
  - Administration and supervision -
    - same supervision as any other provider department
    - HR, 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

Provider-Based: Requirements

- A facility or organization cannot be provider-based if all patient care services are furnished **under arrangement**
  - "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
  - **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

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)

Physician Supervision

- Main building
- On-campus
- Off-campus
- Provider-based setting

Diagnostic Tests

- 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

- 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

Medicare Benefits

- Practitioner benefits
- Physicians
- Nurse practitioners

- Service benefits
- Diagnostic services
- Incident-to services

“Statutory” Practitioners

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Certified Registered Nurse Anesthetist (CRNA)
- Certified Nurse Midwife (CNM)
- Clinical Psychologist (CP)
- Clinical Social Worker (CSW)

“Service” Practitioners

- Occupational Therapist (OT)
- Physical Therapist (PT)
- Audiologist (Aud)
- Speech-Language Pathologist (SLP)
- Registered Dietician (RD)

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 non-hospital 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

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Thank You!