PROVIDER BASED RULES AND PITFALLS

HCCA West Coast Regional Annual Conference
Newport Beach, CA
Friday, June 21, 2013

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Objectives

- Understand background and definitions for Provider-Based Status
- Discuss the requirements for all Provider-Based locations
- Understand the special requirements for Off-Campus Provider-Based locations
- Discuss Provider-Based determinations and the question of Attestation
- Discuss the application of Provider-Based status to Federal health care programs other than Medicare
- Discuss the Government’s concerns with Provider-Based status
- Provide Compliance tips and techniques for monitoring Provider-Based status
Definitions:

- **Provider** - hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program

- **Main Provider** – the provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, financial and administrative control

- **Provider-Based Entity** – a provider of health care services (or RHC) that is either created or acquired by the main provider for the purposes of furnishing health care services of a different type from those of the main provider under the ownership and administrative and financial control of the main provider.
  - Includes physical facility that serves as the site of service, and Personnel and equipment needed to deliver the service
  - Medicare Conditions of Participation Apply

Definitions:

- **Department of the Hospital** – a facility or organization that is created by, or acquired by, a main provider for the purposes of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, financial, and administrative control of the main provider.
  - Includes physical facility, personnel and equipment
  - Medicare CoPs do not apply as a separate entity

- **On Campus** – the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous but are located within 250 years of the main building, and any other areas as determined by CMS

- **Off-Campus** – does not meet the definition of On-Campus

- **Provider-Based Status** – Provider-based entity or Department of the Hospital that complies with the Provider-Based requirements
Not Provider-Based: 42 C.F.R. § 413.65(a)(1)(ii)
- Ambulatory surgical centers
- Comprehensive outpatient rehabilitation facilities
- Home health agencies
- Skilled nursing facilities
- Hospices
- Inpatient rehabilitation units excluded from IPPS for acute hospital services
- Independent diagnostic testing facilities furnishing only services paid under a fee schedule, facilities that furnish only clinical diagnostic laboratory tests, or only a combination of these services
- ESRD facilities
- Ambulances
- Departments without separate payment (medical records)

Unique Reimbursement Methodology

Background

- No specific statutory authority
- CMS Program Memorandum A-96-7
  - August 27, 1996
  - Identify factors of hospital operating an outpatient service
  - Not freestanding service
- No manual provisions
Background

- **Provider-Based Rule:** 42 C.F.R. § 413.65
  - Published April 7, 2000 at 68 Fed. Reg. 18434
  - Effective October 10, 2000
  - Medicare Hospital Outpatient Prospective Payment Rule
- **This is a Medicare Reimbursement Rule**
- **This is not a Medicare Enrollment Rule**
  - Under what circumstances may a hospital properly bill Medicare for hospital outpatient services in “provider-based locations or departments”
  - A service furnished as a hospital outpatient service may have higher reimbursement than if the services had been furnished in another location

Requirements for All:

- **Licensure** 42 C.F.R. § 413.65(d)(1)
  - Hospital and PB entity/department operated under the same license, except where
    - State requires a separate license
    - State law does not permit licensure
- **Financial Integration** 42 C.F.R. § 413.65(d)(3)
  - PB entity/department is fully integrated within the financial system of the hospital
  - Costs are reported as a cost center of the hospital
  - Financial status is incorporated and readily identified in hospital’s balance sheets
- **Public Awareness** 42 C.F.R. § 413.65(d)(4)
  - Entity/department is held out to the public as part of the hospital
  - Patients know they are entering the hospital and billed accordingly
Requirements for All:

- **Clinical Services**
  - Professional staff of the entity has clinical privileges at the hospital
  - Hospital maintains monitoring and oversight just as it does for any other department
  - Medical director maintains a reporting relationship with the Chief Medical Officer, just as any other medical director
  - Medical staff committees at the hospital are responsible for medical activities in the entity
    - Utilization review
    - Coordination and integration of services
    - Peer review
  - Medical records are integrated into the hospital medical record system
  - Patients have full access to all services of the hospital

42 C.F.R. § 413.65(d)(2)

Requirements for All:

- **On-Campus entities must comply with EMTALA**
- **Off-Campus entities must comply with EMTALA if they qualify as a Dedicated Emergency Department**
- Physician services must be billed with the correct (hospital) place of service
- Entity must comply with the Hospital's provider agreement
- Physicians are obligated to comply with Medicare non-discrimination provisions
- Payments are subject to the 3-day payment window provisions for PPS hospitals (1 day for non-PPS)
- Entity must meet applicable hospital health and safety rules for Medicare-participating hospitals

42 C.F.R. § 413.65(g)
Co-Insurance for Medicare Beneficiaries

42 C.F.R. § 413.65(g)(7)

- Provider-based services may subject a Medicare Beneficiary to two separate co-payments
  - Outpatient Hospital Visit
  - Physician Visit
- Written Notice to Beneficiary Required
  - Amount of Beneficiary's Potential Liability
  - Explanation that Beneficiary will incur liability that would not exist but for provider-based status of facility

Off-Campus Requirements:

42 C.F.R. § 413.65(e)

- Operation under the ownership and control of the main provider
  - 100% owned by the main provider – No Joint Ventures
  - Same governing body as the main provider
  - Operates under the same organizational documents as the main provider
  - The main provider has final responsibility for administrative decisions, contracts, personnel actions, policies, and medical staff appointments
- Administration and Supervision
  - The entity is under the direct supervision of the main provider
  - Operated under the same monitoring and oversight as any other department
  - Entity director:
    - Has reporting relationship to the main provider
    - Is accountable to the governing body of the main provider
  - Administrative functions are integrated (billing, medical records, human resources, payroll, employee benefits, salary structures)
Off-Campus Requirements (cont.)

- Location (one of the following must be satisfied)
  - 35-mile radius of the campus of the main provider
  - Main provider has a disproportionate share adjustment greater than 11.75%, and is
    - Owned or operated by a unit of State or local government
    - A public or nonprofit corporation that is granted governmental powers
    - A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus
  - Demonstrates a high level of integration with the main provider and serves the same population
  - The entity is an RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area

Special Circumstances:

- **Joint Ventures**
  42 C.F.R. § 413.65(f)
  - Be partially owned by at least one provider
  - Be located on the main campus of a provider who is a partial owner
  - Be provider-based to the one provider on which the entity is located
  - Meet all other requirements to be provider-based

- **Management Agreements**
  42 C.F.R. § 413.65(h)(1)
  - Non-management, non-clinical staff should be employees of the main provider
  - Administrative functions must be integrated
  - Main provider has control over the operation
  - Main provider holds contract with management organization
Attestation: To Do or Not to Do?

- Effective 10/1/02 – mandatory requirement for provider-based determinations replaced with a voluntary attestation process.
- Advantage – if approved and CMS subsequently discovers entity does not meet requirement, CMS would not recover all past payments only the difference between what was paid and what should have been paid if correctly classified and billed.
- Disadvantage – burdensome process, may need to “re-attest” for material program changes to maintain advantage of attestation.

Provider-Based Application to Federal Health Care Programs other than Medicare

It depends

- Medicaid – NO
  See 74 Fed. Reg. 21234 (May 6, 2009)
- Tri-Care –
  ◦ Yes, Generally
  ◦ NO if Children’s or Cancer Hospital
Government Concern

• Same services, different reimbursement
  ◦ In physician office:
    • Entire service paid under the physician fee schedule
  ◦ In outpatient department:
    • Physician component reduced
    • Technical component paid separately
    • Net effect = higher reimbursement for provider, greater cost sharing for beneficiaries

• Significant increase in the number of physician office visits provided in provider-based sites

Government Concern

• OIG Work Plan
  ◦ 2011 – Determine the appropriateness of the provider-based designation and impact to Medicare and beneficiaries
  ◦ 2013 – Determine the impact of non-hospital-owned physician practices billing Medicare as provider-based and determine extent to which these practices meet billing requirements
Government Concern

- OIG Correspondence: May, 2013
  - “Evaluation to determine the number of provider-based facilities”
  - Online Survey Request: “Does your hospital own or partially own any off-campus outpatient departments that are paid as provider-based departments of your hospital?”
  - Questions Focused on Off-Campus: “You will be asked the following questions for each off-campus outpatient department that is paid as a provider-based department of your hospital.”
- Who Has Received This Letter? (IV)

MedPAC Recommendations

- January 2012 – E&M services paid to outpatient departments be lowered to payments made in doctors’ offices
- November 2012 – Equalize reimbursement for certain other services similar to those typically provided in stand-alone doctors’ offices
  - Services performed in a doctor’s office most of the time
  - Services that do not involve many other tests or procedures
  - Services that don’t involve an ER visit
  - Services with few differences in the sickness of the patient
- If implemented estimated to save $780 million to Medicare and $220 million to beneficiaries
- If implemented hospital revenue expected to decline 5.5% for outpatient services and 1.2% overall
Compliance with Provider-Based Rules

- Tip: Use your MAC attestation form as your audit guide
- Know all your entities
  - Where are they located?
  - How are they structured?
  - How are they governed and managed?
  - How are you billing?
- Refresh your inventory of entities annually
- Understand your corporate strategy
  - Are you planning on adding additional sites?
  - Do you have “alignment” and “integration” strategies that may affect provider-based status?

Compliance with Provider-Based Rules

- On-Campus or Off-Campus
  - Verify the address and exact distance between the main provider and the PB entity
  - Document with Internet map and site map
- Licensure
  - Obtain a copy of the state license
  - If separate license is required by the State, obtain copy of licensure requirements
- Financial Integration
  - Review hospital chart of accounts and/or trial balance showing the revenue and expenses for the entity are integrated
Compliance with Provider-Based Rules

- Clinical Services
  - Confirm that professional staff are privileged at the hospital
  - Review organizational chart – make sure staff are employed by the hospital and report up to hospital management
  - Review medical staff bylaws, committee meeting minutes, etc. – make sure Medical Director is reporting to appropriate hospital medical staff committee and the Chief Medical Officer

Compliance with Provider-Based Rules

- Medical Records
  - Review medical records policy – ensure control of the entity record is responsibility of hospital HIM executive
  - Test record retrieval system – are both main hospital and entity records combined?
- Integrated inpatient/outpatient services
  - Confirm patients have access to all hospital services
  - Review frequency of patient movement between various hospital services
Compliance with Provider-Based Rules

- Public Awareness
  - Review signage, patient registration forms, letterhead, web sites, advertisements, etc – is it clear that patients are receiving services from the hospital?
  - “Affiliated with” language may not be ok

- EMTALA
  - Confirm that EMTALA policies apply to provider-based entities
  - Consider EMTALA “table-top” drill

Compliance with Provider-Based Rules

- Billing
  - Pull sample of 1500’s and UB’s to confirm both professional and hospital services are billed with a site-of-service code 22, outpatient hospital

- 3-Day Payment Window
  - Review services provided within 3 days of an inpatient stay – were they bundled into the DRG as required?
Compliance with Provider-Based Rules

- Off-Campus
  - Review articles of incorporation and bylaws for the hospital and entity – confirm 100% ownership by the hospital and control by the hospital’s governing body
  - Review policies and procedures of hospital and entity – confirm the hospital has the final authority over contracts, personnel policies, medical staff appointments, etc.
  - Confirm direct administrative supervision over the entity by the hospital (reporting relationships)
  - Confirm administrative functions are integrated with the hospital (billing, medical records, HR, Payroll, purchasing, etc.)

Compliance with Provider-Based Rules

- Off-Campus (continued)
  - Verify entity is located within 35 miles of the hospital
  - If more than 35 miles – confirm an exception applies
  - Confirm Medicare Beneficiary notice of potential financial liability is being provided, before service is delivered
    - Beneficiary can read and understand the notice
    - If exact type of care is not known, notice explains that the beneficiary will incur coinsurance liability that would not be incurred if the facility were not provider-based
    - Notes liability may vary if estimated
Compliance with Provider-Based Rules

- If Joint Venture:
  - Confirm that entity is partially owned by hospital
  - Confirm that entity is on the partial owner hospital campus

- If Management Agreement
  - Confirm staff are employed by hospital
  - Confirm administrative functions are integrated with the hospital

Audit Concerns: What Next?

- Face any Potential Problems Head On
- Consult with Counsel
- Overpayments?
- Remember 60 Day Rule

- Recovery by CMS 42 C.F.R. § 465.13(j)
  - Difference between amount paid by CMS and amount that should have been paid without provider-based status
QUESTIONS?

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