Provider-Based Status

Donald Anderson
Director Reimbursement Administration
Providence Health & Services

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Agenda

- What is Provider-Based Status?
- Background and Reasons for Provider-Based Status
  - Overview of the Provider-Based Regulations and Attestation Requirements
  - Why is an Attestation Important?
- What else is Required?
- 340b Implications
- Critical Access Hospital Concerns
- Major Concerns with Pursuing Provider-based Status

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What is Provider-Based Status?

- Provider-based status describes the relationship between a main hospital and a;
  - department of a provider,
  - provider-based entity,
  - remote location of a hospital or
  - satellite facility.
- Provider-based status means the location bills as part of the hospital to which it is provider-based
  - Professional Claim (Physician Services) on CMS 1500 with the appropriate Site of Service (21 for Hospital Inpatient or 22 for Hospital Outpatient)
  - Technical Claim (Hospital Services) on UB-04

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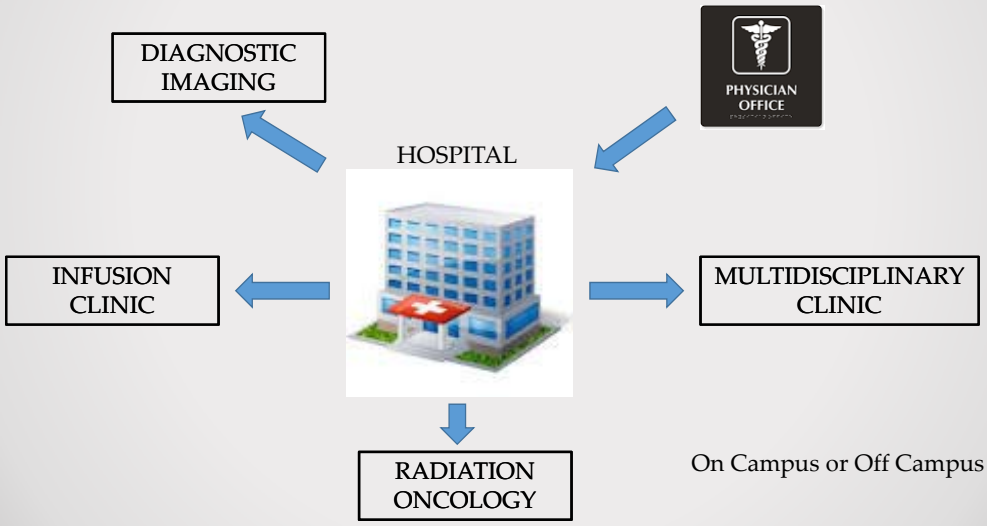
Provider-Based Status Examples



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Background and Reasons for Provider-Based Status

- 42 CFR 413.65 is the Medicare Regulation which governs provider-based status
- CMS provided guidance on provider-based status through Transmittal A-03-030 (Dated April 18, 2003)
- Provider-based regulations apply to Medicare and Medicaid primarily, but Commercial Payers may also be impacted:
  - Medicare typically pays more for provider-based locations than freestanding locations
  - Depending on your contracts with commercial payers, they may also be required to pay a higher rate for hospital services provided in off campus provider-based locations
- The provider-based attestation process is voluntary
  - If you don't attest, however, there is financial risk should your location be found (by CMS/MAC) to not meet the requirements, but you have been billing as provider-based in the interim
  - In order to receive confirmation of provider-based status, all requirements must be met

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Provider-Based Attestations

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Attestations Are Not Required For:

42 CFR §413.65 is not applicable to provider based status of:

- ASCs, CORFs, HHAs, SNFs, Hospices
- Inpatient rehab units
- IDTF's and clinical labs paid only on fee schedule
- PT/OT/ST unless at a CAH or caps suspended*
- ESRD - see §413.174
- Ambulance
- Non-revenue producing departments

Note: Many of the above entities have their own Medicare enrollment, so the concept of provider-based status is not applicable.

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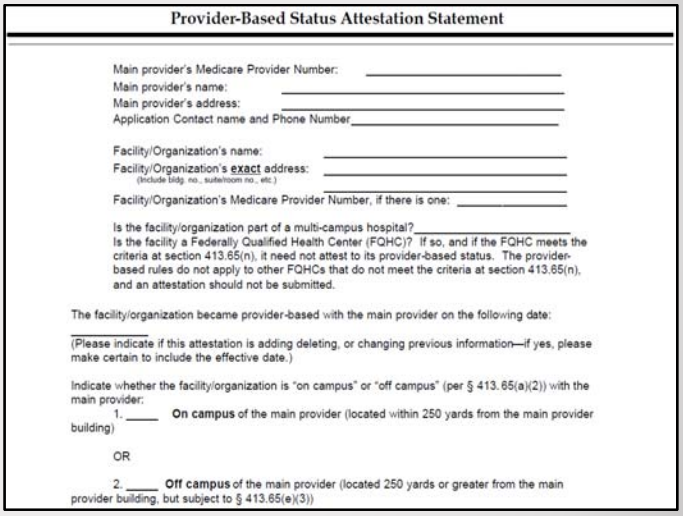
Provider-Based Attestation

- The following example is commonly accepted by Medicare Administrative Contractors (MAC) when attesting
- You must identify
  - The main hospital
    - Name
    - Location
    - Medicare Number
  - The provider-based
    - Name
    - Location
    - On or Off Campus Location, and
- The following:



Provider-Based Status Attestation Statement

Main provider's Medicare Provider Number: _____
Main provider's name: _____
Main provider's address: _____
Application Contact name and Phone Number_____

Facility/Organization's name: _____
Facility/Organization's **exact** address: _____
(Include bldg. no., suite/room no., etc.)
_____
Facility/Organization's Medicare Provider Number, if there is one: _____

Is the facility/organization part of a multi-campus hospital?_____
Is the facility a Federally Qualified Health Center (FQHC)? If so, and if the FQHC meets the criteria at section 413.65(n), it need not attest to its provider-based status. The provider-based rules do not apply to other FQHCs that do not meet the criteria at section 413.65(n), and an attestation should not be submitted.

The facility/organization became provider-based with the main provider on the following date:

_____
(Please indicate if this attestation is adding deleting, or changing previous information—if yes, please make certain to include the effective date.)

Indicate whether the facility/organization is "on campus" or "off campus" (per § 413.65(a)(2)) with the main provider:

1. ____ **On campus** of the main provider (located within 250 yards from the main provider building)

OR

2. ____ **Off campus** of the main provider (located 250 yards or greater from the main provider building, but subject to § 413.65(e)(3))

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Attestation Requirements

Requirement	Implication
Licensure	The department of the provider, remote location of the hospital, or satellite facility and the main provider are operated under the same license.
Clinical Services Integration	- Professional staff of the provider-based location have ***privileges*** at the main provider. - The main provider maintains the same ***oversight*** of the provider-based location as it does for any other department of the provider. - The Medical Director/Manager of the provider-based location maintains a ***reporting relationship*** with the chief medical officer/official of the main provider that has the ***same frequency, intensity, and level of accountability as any other department of main provider.*** - ***Medical Staff Committees*** of the main provider are responsible for medical activities in the provider-based location, including quality assurance, utilization review, and coordination of services.
Financial Integration	The financial operations of the provider-based location are fully integrated within the financial system of the main provider. Shared income and expenses can be demonstrated with a working trial balance of expenses.

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Attestation Requirements (cont.)

Requirement	Implication
Public Awareness	The provider-based location is held out to the public and other payers as part of the main provider. This can be demonstrated with appropriate signage, letterhead, business cards and web-site content.
Obligations of Outpatient Departments	- ***EMTALA/antidumping rules*** apply if the provider-based location is held out to the public as an Emergency Department. - ***Physician services must be billed with site of service 22***. - The main hospital's ***provider agreement applies*** to the provider-based location. - ***Non-discrimination provisions*** apply to provider-based location. - All patients seen at the provider-based location must be treated as ***hospital patients***. - The ***72-hour payment rule*** for IPPS applies to services provided in the provider-based location. - Patients in Off-campus locations must be ***notified that they are subject to a hospital and physician copay/coinsurance***.

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Beneficiary Liability Notice

- The notice must be one the patient can read and understand
- If the exact type and extent of care is not known, the hospital must provide notice that the patient will be subject to both a professional/physician and hospital/technical coinsurance liability along with an estimate of the average charges, while stating "the patient's actual liability will depend upon the actual services provided by the hospital"
- If the patient is unable to receive the written notice due to being unconscious or under great duress, the notice must be provided their authorized representative
- In emergent situations, notice can be provided after the patient has been stabilized, if applicable

Note: A BLN is not an Advance Beneficiary Notice (ABN), which may also apply to select services.

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Attestation Requirements (cont.)

Requirement	Implication
Ownership and Control (*Off* campus locations only)	- The business enterprise is ***100% owned by the main provider***. - The main provider and the provider-based location have the ***same governing body.*** - The main provider and the provider-based location share ***common bylaws***. - The main provider has ***final responsibility*** for ***administrative decisions***, final ***approval for contracts*** and ***personnel actions and policies***, and final approval for ***medical staff appointments***.
Administration and Supervision (*Off* campus locations only)	- The provider-based location is under ***direct supervision*** of the main provider. - ***Supervision and accountability of the provider-based location is the same as any other department of the main provider***. - The reporting relationship of a manager at the provider-based location is the ***same frequency, intensity and level of accountability as any other department***.

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Attestation Requirements (cont.)

Requirement	Implication
Administration and Supervision (cont.) (***Off*** campus locations only)	- ***Administrative functions*** such as billing, records, human resources, payroll, employee benefits, salary structure and purchasing are integrated between the provider-based location and main provider.
Location - ***On Campus*** generally means ***within 250 yards*** of the main provider. - ***Off Campus*** is located ***within 35 miles*** of the main provider. - ***Remote Off Campus*** is more than 35 miles (subject to other criteria)	The provider-based location must be in the ***immediate vicinity*** of the main provider based on one of the following criteria: - Located on the ***same campus***. - Is an RHC located in a rural area with fewer than 50 beds. - Is located ***within 35 miles*** of the main provider. - The provider-based location demonstrates a ***high level of integration*** and demonstrates that it serves ***the same population as the main provider*** through the zip code test - Other

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Attestation Requirements (cont.)

Requirement	Implication
Management Contracts (***Off*** campus locations only)	- Generally, ***the hospital should employ the staff of the provider-based location*** involved in the delivery of patient care and may not lease employees from the management company. - Exceptions: management staff and staff who furnish patient care services reimbursed under the physician fee schedule. - The ***administrative functions are integrated with the main provider***. - The main provider has ***significant control*** over the operations of the provider-based location. - The management contract is held by the main provider.
Joint Ventures (Allowed for ***On campus*** locations only)	- The provider-based location must be partially ***owned by one main provider***. - The provider-based location must be ***located on the main campus of the main provider who is partial owner*** and must be provider-based to that location.
Under Arrangements	A facility or location may not qualify for provider-based status if all patient care services are provider under arrangements.

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Why is an Attestation Important?

- Positive Confirmation from CMS/MAC that the location meets the requirements of 42 CFR 413.65
- Have the approval letter in your permanent files should you need it
  - Approval letter from CMS can be used with other payers to confirm location is part of the hospital
- Limit the risk of overpayments both retrospectively and prospectively
  - The date a complete attestation is submitted is important to limit the dates CMS can recoup additional payments if the location is ultimately found to not meet the requirements

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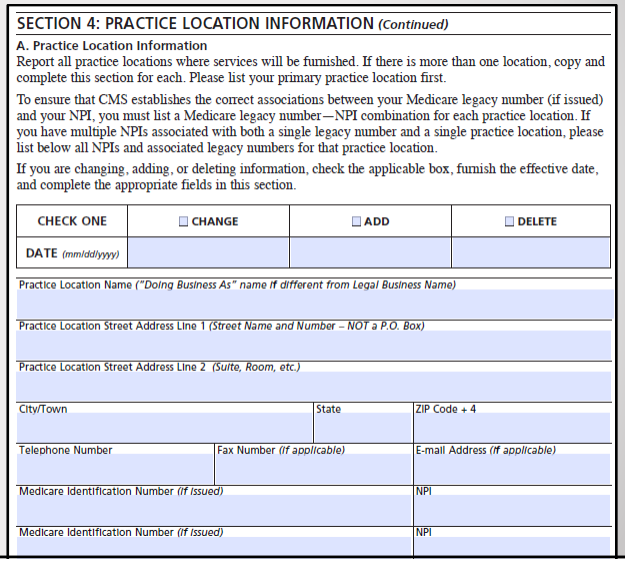
What Else is Required When Attesting to Provider-Based Status?

- The provider-based location must be added as a Practice Location must be added to the hospital's Medicare Enrollment (855A)
- The practice location must be added to the Joint Commission listing of practice locations
- The practice location must be added to the hospital's license
- Report on the Medicare Cost Report



SECTION 4: PRACTICE LOCATION INFORMATION *(Continued)*

A. Practice Location Information

Report all practice locations where services will be furnished. If there is more than one location, copy and complete this section for each. Please list your primary practice location first.

To ensure that CMS establishes the correct associations between your Medicare legacy number (if issued) and your NPI, you must list a Medicare legacy number—NPI combination for each practice location. If you have multiple NPIs associated with both a single legacy number and a single practice location, please list below all NPIs and associated legacy numbers for that practice location.

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

CHECK ONE	☐ CHANGE	☐ ADD	☐ DELETE
DATE *(mm/dd/yyyy)*			

Practice Location Name *("Doing Business As" name if different from Legal Business Name)*

Practice Location Street Address Line 1 *(Street Name and Number – NOT a P.O. Box)*

Practice Location Street Address Line 2 *(Suite, Room, etc.)*

City/Town	State	ZIP Code + 4

Telephone Number	Fax Number *(if applicable)*	E-mail Address *(if applicable)*

Medicare Identification Number *(if issued)*	NPI
Medicare Identification Number *(if issued)*	NPI

340b Considerations

340b savings can be extended to provider-based locations identified as child sites of a covered entity:

- Must be an outpatient location
- Must appear on the most recently filed hospital cost report
- Must be open and seeing patients and the cost report must be submitted, which can lead to long lead times
- Registration of child sites is limited to specified time periods as well (15 days each Calendar Quarter), so participation is dictated by the timing of registration

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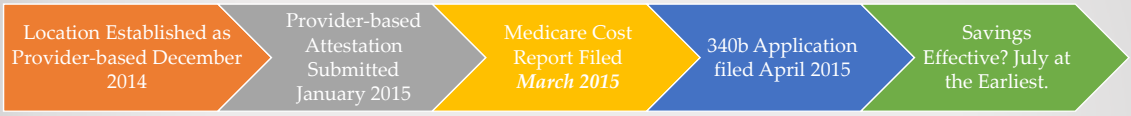
Aggressive Timeline



Common Timeline

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Off Campus vs. Off-site

- The Provider-based Regulations generally define On Campus as locations within 250 yard of the main provider location.
- Off Campus as beyond 250 yards of the main provider.
- For 340b, Off-Site is defined as outside of the four walls of the main provider
- Note: You may have a location that is considered On Campus for provider-based regulations, but Off-site for 340b

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Critical Access Hospital (CAH) Concerns

- As of January 1, 2008, all CAHs, including necessary provider CAHs that create or acquire an off-campus, provider-based facility, must meet the CAH distance requirement of a 35-mile drive to the nearest hospital or CAH (or 15 miles in the case of mountainous terrain or secondary roads).
  - Excludes Rural Health Clinics
  - The provider-based location itself must meet the distance requirement from another hospital or CAH
- The status of the provider as a CAH would be jeopardized and subject to termination should the CAH violate this rule.
- Exceptions made for locations "under development" as defined in the rulemaking process.

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Major Concerns

- CMS has expressed growing concerns as physician offices are being converted to provider-based for billing to Medicare/Medicaid
- Medpac Recommendations – Payment Parity between (hospital) provider-based locations and freestanding physician offices/entities:
  - Evaluated 450 APCs and isolated 66 (1) that do not require emergency care, do not have extra costs associated with higher patient complexity in a hospital setting, and do not require the additional overhead expense when provided in a hospital setting to determine financial impact of moving from OPPS to PFS rates.
  - Isolated 12 groups of services commonly performed in an ASC for which the OPPS rate could be reduced to the ASC level.
  - Reduce E&M (Evaluation & Management) clinic visit payment rates to be equal to Physician Fee Schedule amounts.

(1) Services are frequently performed in a physician office more than 50% of the time.

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Example: Medicare and Beneficiary's Responsibility E&M Office Visit

	Freestanding	Provider-based Location		
	Service in Physician Office	Physician Facility Rate	OPPS/APC Rate	Total OPD Rate
Program Payment	***$62.66***	$42.50	$77.00	***$119.50***
Beneficiary Cost Sharing	***15.66***	10.63	19.25	***29.88***
Total Payment	***$78.32***	$53.13	$96.25	***$149.38***

Note: This calculation is similar to that provided by MedPac in their June 2013 Report to Congress, but has been updated with 2015 figures. E&M (Evaluation & Management), OPD (hospital outpatient department), OPPS (Outpatient Medicare Prospective Payment System). Terminology code for this visit is 99213/G0463.

Source: 2015 Medicare Physician Fee Schedule, WA-Locale 2 and 2015 Addendum B – January 2015 Version

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Example: Medicare and Beneficiary's Responsibility Transesophageal Echo (MedPac)

	Freestanding	Provider-based Location		
	Service in Physician Office	Physician Facility Rate	OPPS/APC Rate	Total OPD Rate
Program Payment	***$121.17***	$121.17	$338.20	***$459.37***
Beneficiary Cost Sharing	***30.29***	30.29	84.55	***114.84***
Total Payment	***$151.46***	$151.46	$422.75	***$574.21***

Note: This calculation is similar to that provided by MedPac in their June 2013 Report to Congress, but has been updated with 2015 figures. Additionally, the MedPac example was for E&M (Evaluation & Management), OPD (hospital outpatient department), OPPS (Outpatient Medicare Prospective Payment System). The calculation has been updated for Transesophageal Echo, CPT Code 93315.

Source: 2015 Medicare Physician Fee Schedule, WA-Locale 2 and 2015 Addendum B – January 2015 Version

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Example: Medicare and Beneficiary's Responsibility Lumbar Nerve Block (at ASC Rates)

	Payment at Medicare ASC Rates			Payment at Medicare OPPS Rates		
	Physician Payment	ASC Payment	Total ASC Rate	Physician Facility Rate	OPPS/APC Rate	Total OPD Rate
Program Payment	$167.15	$307.65	***$474.80***	$167.15	$537.64	***$704.79***
Beneficiary Cost Sharing	41.79	76.91	***118.70***	41.79	134.42	***176.21***
Total Payment	$208.94	$384.56	***$593.50***	$208.94	$672.06	***$881.00***

Note: This calculation is similar to that provided by MedPac in their June 2013 Report to Congress, but has been updated with 2015 figures. Additionally, the MedPac example was for E&M (Evaluation & Management), OPD (hospital outpatient department), OPPS (Outpatient Medicare Prospective Payment System). The calculation has been updated for Lumbar Nerve Block, CPT code 64520.

Source: 2015 Medicare Physician Fee Schedule, WA-Locale 2 and 2015 Addendum B – January 2015 Version, Noridian ASC Fee Schedule effective January 1, 2015 - Washington

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What is CMS Doing?

- CMS is gathering data for off-campus locations:
  - Billing Modifier for Hospital Billing (-PO) (Voluntary in 2015 and mandatory Jan. 2016)
    - Services, procedures/surgeries furnished at off-campus provider-based outpatient departments
  - Place of Service Code for Physician Billing (Jan. 2016)
    - On-campus, remote or satellite location of a hospital
    - Off-campus provider-based hospital setting
- CMS plans to use this data are unknown

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Key Takeaways

- Provider-based status is a Medicare/Medicaid payment issue subject to a complicated set of rules
- Provider-based status generally refers to a location and not necessarily individual services
- Provider-based locations are subject to Medicare hospital payment and Conditions of Participation rules
- Non-compliance with the rules can lead to recoupment

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What Should You Be Doing?

- Assess current provider-based locations
- Review for compliance with 42 CFR 413.65
- Confirm attestations have been submitted AND approved (sometimes approval can take months)
- Confirm your Medicare Enrollment is up-to-date and in sync with your practice locations
- Verify your Joint Commission practice locations are current
- Review for 340b implications

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Questions?

Donald Anderson, Director Reimbursement Administration
Providence Health & Services

Donald.AndersonJr@providence.org
(425) 525-5392

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