PROVIDER BASED AND FREESTANDING CLINICS

CMS OPERATIONAL REQUIREMENTS & PAYMENT METHODOLOGIES

Healthcare Financial Management Association
Washington-Alaska Chapter
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PROVIDER-BASED SERVICES – WHAT AND WHY?

- What is Provider Based Status?
  - Services provided are considered “hospital” services
  - Provider Based designation may apply to:
    - Hospital Outpatient diagnostic and therapy services
    - Physician Practices
    - Ambulatory Surgery Centers
    - Home Health Agencies
    - SNFs
    - Medicare Certified Rural Health Clinics

- Why?
  - Increased reimbursement for like services provided in Non Provider Based entity

DEFINITIONS

- Main provider
  - A provider that creates or acquires another entity to deliver additional health care services under its name, ownership, and financial and administrative control.
- On-Campus
  - 250 yards from “main buildings”
  - Exceptions on a case-by-case basis
- Provider
  - A hospital

DEFINITIONS

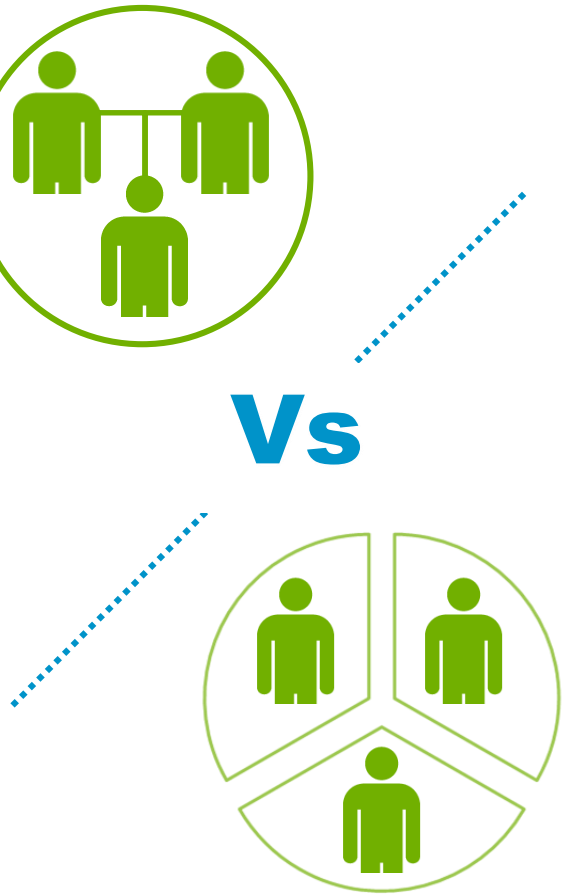
- Provider-based entity
  - Created or acquired by a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider.
  - Includes both the specific physical facility and the personnel and equipment needed to deliver the services at that facility.

PROVIDER BASED REGULATIONS

- 42 CFR 413.65 (CCH ¶4306)
- Requirements for all provider-based entities:
  - Subject to Hospital's Medicare Conditions of Participation and Payment
  - Operate under the same license as the main provider, unless:
    - Entity can be licensed separately
    - State requires separate license, or does not allow the entity to be included under hospital's license
  - Share integrated clinical services
  - Financial integration
  - Public Awareness

PROVIDER BASED REGULATIONS – WHAT DO THEY MEAN?

- Requirements for all provider-based entities (Continued):
  - Integrated clinical services
    - Complete and total – no “we” and “they”
    - Medical staff has privileges at main provider (to include APPs if applicable)
      - Practices/clinics fall under the Hospital’s Medical Staff By Laws
    - Clinical oversight is the same as for all other clinical departments of main provider
    - Medical records “integrated into a unified retrieval system (or cross-reference) of the main provider.”
      - CMS says, “Practitioners in either location can obtain relevant information about care in the other setting.”



PROVIDER BASED REGULATIONS – WHAT DO THEY MEAN?

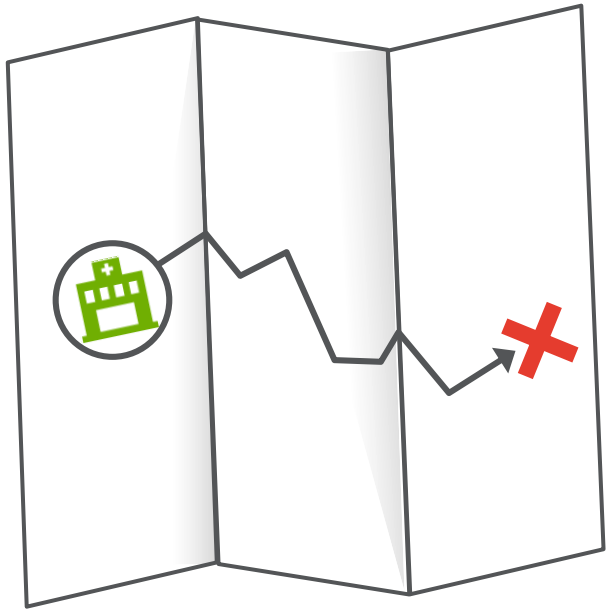
- Requirements for all provider-based entities (Continued):
  - Financial Integration
    - Entity is a department or cost center on main provider's books
    - Shared income and expenses
    - Complete and total integration

PROVIDER BASED REGULATIONS – WHAT DO THEY MEAN?

- Requirements for all provider-based entities (Continued):
  - Public Awareness
    - Entity must be held out to the public as part of the main provider. Must be obvious to the patient that they are in hospital space/department.
    - Signs, letterhead, patient statements, employee ID badges, business cards, etc. must show main provider's name.

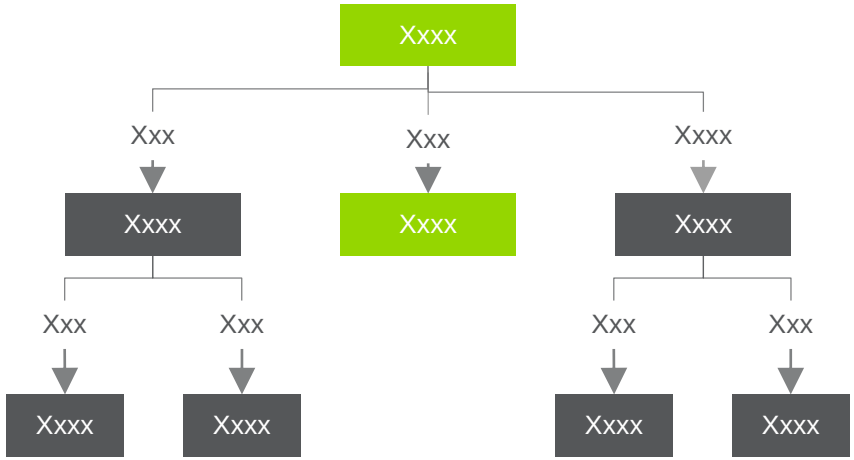
PROVIDER BASED REGULATIONS – WHAT DO THEY MEAN?

- Off-campus entities
  - Off-campus means located more than 250 yards from “main buildings” of main provider
  - Off-campus sites that provide the same services as a physician office are assumed to be **freestanding**
  - Must meet same requirements as on-campus, plus additional requirements



PROVIDER BASED REGULATIONS – WHAT DO THEY MEAN?

- Off-campus entities (continued)
  - Ownership and control by main provider
    - 100% owned by the main provider
      - Can’t be owned by parent or sister corporation
    - Same governing body
    - Same organizational documents (bylaws)
    - Main provider has final responsibility for administrative decisions, contracts, personnel actions, personnel policies, and medical staff appointments



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PROVIDER BASED REGULATIONS –WHAT DO THEY MEAN?

- Off-campus entities (continued)
  - Administration and supervision
    - Integration of administrative functions
      - Billing, records, human resources, payroll, employee benefit package, salary structure, and purchasing services.
      - Handled by same employees, under the same contract, or under different contracts where both contracts are held by the main provider.

PROVIDER BASED REGULATIONS – WHAT DO THEY MEAN?

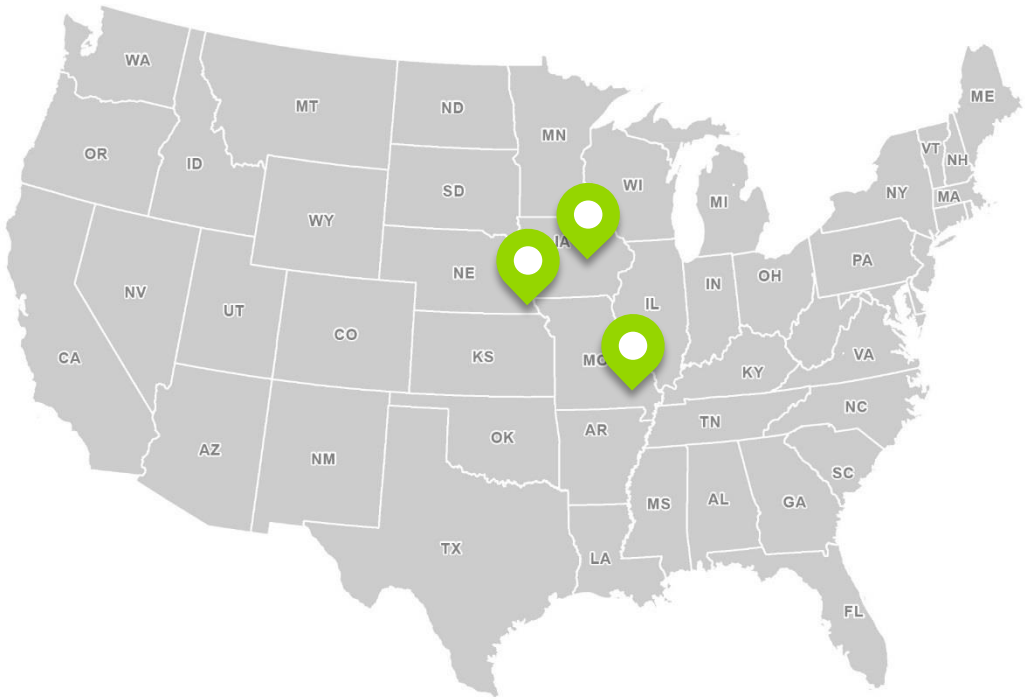
- Off-campus entities (continued)
  - Location
    - Within a 35-mile radius of the campus of the main provider, except when
      - Main provider has a DSH adjustment greater than 11.75%, and
      - Is owned or operated by a governmental or quazi-governmental agency, or contracts with state or local government to operate clinics for low-income, non-Medicare or Medicaid patients

PROVIDER BASED REGULATIONS – WHAT DO THEY MEAN?

- Off-campus entities (continued)
  - Location
  - Serves the same patient population
    - 75% of entity's patients live in the same ZIP codes as 75% of main provider's patients, or
    - 75% of entity's patients who need services offered by main provider are treated by main provider, or
    - If entity was not in operation for 12 months, it is located in one of the ZIP codes that makes up 75% of main provider's business

PROVIDER BASED REGULATIONS – WHAT DO THEY MEAN?

- Off-campus entities (continued)
  - Location
    - Must be located in the same State or adjacent States
    - RHCs attached to hospitals with less than 50 beds are exempt from some of these location criteria



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OTHER PROVIDER-BASED ISSUES

- EMTALA
- Bill with correct site of service code
  - 22 for provider-based clinic
  - 11 for freestanding clinic

OTHER PROVIDER-BASED ISSUES

- Sharing space with other departments or entities
- DRG window applies
- Must meet life safety code requirements
- Joint Commission and/or other Accreditation
- Ancillary Services
  - Lab
  - X-Ray
  - EKG

OTHER PROVIDER-BASED ISSUES

- Management Contracts
  - Contract must be held by main provider, not a parent or sister
  - Contract must state:
    - Provider has control
    - Contractor staff are subject to hospital policies and procedures
    - Contractor's policies must be approved by provider
    - Requirement for periodic written reporting
  - If for an off-campus site, the provider's control must be clear and the provider must employ all employees who furnish direct patient care

CMS RECOGNITION

BIPARTISAN BUDGET ACT OF 2015

OFF-CAMPUS PROVIDER BASED CLINICS/DEPARTMENTS

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BIPARTISAN BUDGET ACT OF 2015
OFF-CAMPUS, PROVIDER-BASED CLINICS/DEPARTMENTS – WHAT CHANGED?

- Act signed into law by President Obama on Nov 2, 2015
- Institutes first “site neutral” payment for “new” off campus provider based departments!
  - Savings estimated at $9.3 billion over 10 years
  - CMS estimates $50 million just in 2017

OPPPS: 2017 FINAL RULE
OFF-CAMPUS, PROVIDER-BASED SERVICES – BACKGROUND

Establishing a provider-based service

- Medicare Enrollment Application, Form 855, updated within 90 days
- File attestation statement: Voluntary
  - Recoupment of overpayments starts from date of attestation filing

Billing and reimbursement

- Hospital:
  - Bill for services as hospital outpatient service, technical component via CMS UB04
  - Paid under OPPPS, APC for patient encounter
- Physician professional services billed as well
  - Just like other hospital departments
  - Bill filed on CMS 1505 form
  - Reimbursed at reduced rate under Physician Fee Schedules

Modifier "PO" on claims when "off-campus"

- Adopted on Jan 1, 2015, voluntary only
- Mandatory use of PO on Jan 1, 2016

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OP PPS FINAL RULE: OFF-CAMPUS, PROVIDER-BASED SERVICES/DEPARTMENTS/CLINICS

- Grandfathers existing off-campus, provider-based services
  - Billed as provider-based *before Nov. 2, 2015*
  - Referred to as “Excepted” services by CMS
  - Reimbursement remains the same
- Effective Jan 1, 2017 :
  - New Off-campus, provider-based departments defined as any service with provider based designation *on or after Nov. 2, 2015*
  - “Site Neutral Payments” instituted on these services
  - All billing and reimbursement will be under Physician Fee Schedules
- Medicare reimbursement advantage to provider based status reduced
  - Does not apply to Rural Health Clinics or Critical Access Hospitals
  - 340B program still available to provider based departments

OPPPS: 2017 FINAL RULE
OFF-CAMPUS, PROVIDER-BASED SERVICES: RELOCATIONS

- CMS will not recognize relocations as “Excepted” provider-based clinics and services
  - Provider-based status & designation is specific to physical location
  - Relocation of physical space and address, including moving from one suite in a MOB to another in same MOB considered relocation
  - CMS will look to address reported on Form 855
  - Expansions, including into adjoining “space” ?
    - CMS notes this applies to “Suite #”
  - CMS will utilize CMS Form 855 Enrollment for purposes of determining/verifying addresses

OPPPS: 2017 FINAL RULE
OFF-CAMPUS, PROVIDER-BASED SERVICES: RELOCATIONS

- CMS will consider temporary relocation due to Extraordinary Circumstances:
  - Natural disasters
  - Significant seismic building codes
  - Significant public health and safety issues
  - All above necessitate moving to a new building
- Will be reviewed by CMS on case by case basis
  - Sub Regulatory Guidance will be issued
  - Limited and rare instances

OPPPS: 2017 FINAL RULE
OFF-CAMPUS, PROVIDER-BASED SERVICES – EXPANSION OF SERVICES

- CMS Proposed to Limit expanding services at provider based clinics
  - Limit applied to items and services by type
    - Could not start providing ENT services at Family Practice location
  - CMS Provided Table, following slide, defining service types by clinical family
    - Will map by HCPCS/CPT/APC as illustrated in Table 21
    - Service on Table 21 not provided on Nov 1, 2015 would not be recognized nor paid as provider based service

OPPPS: 2017 FINAL RULE (TABLE FROM PROPOSED RULE) OFF-CAMPUS, PROVIDER-BASED SERVICES – ISSUES (CONTINUED)

TABLE 21.—PROPOSED CLINICAL FAMILIES OF SERVICES FOR PURPOSES OF SECTION 603 IMPLEMENTATION

Clinical Families	APCs
Advanced Imaging	5523-25, 5571-73, 5593-4
Airway Endoscopy	5151-55
Blood Product Exchange	5241-44
Cardiac/Pulmonary Rehabilitation	5771, 5791
Clinical Oncology	5691-94
Diagnostic tests	5721-24, 5731-35, 5741-43
Ear, Nose, Throat (ENT)	5161-66
General Surgery	5051-55, 5061, 5071-73, 5091-94, 5361-62
Gastrointestinal (GI)	5301-03, 5311-13, 5331, 5341
Gynecology	5411-16
Minor Imaging	5521-22, 5591-2
Musculoskeletal Surgery	5111-16, 5101-02
Nervous System Procedures	5431-32, 5441-43, 5461-64, 5471
Ophthalmology	5481, 5491-95, 5501-04
Pathology	5671-74
Radiation Oncology	5611-13, 5621-27, 5661
Urology	5371-77
Vascular/Endovascular/Cardiovascular	5181-83, 5191-94, 5211-13, 5221-24, 5231-32
Visits and Related Services	5012, 5021-25, 5031-35, 5041, 5045, 5821-22, 5841

OPPPS: 2017 FINAL RULE
OFF-CAMPUS, PROVIDER-BASED SERVICES – EXPANSION OF SERVICES

- CMS is NOT implementing Service Expansion Limitation as proposed
  - Administratively Cumbersome
  - Will monitor services provided at Excepted Locations
  - Will develop limitation policy in future rule making
  - CMS feels very strongly that BiPartisan Budget Act provides authority to limit service expansions at excepted site locations

OPPPS: 2017 FINAL RULE
OFF-CAMPUS, PROVIDER-BASED SERVICES – ISSUES

- Change of ownership
  - Provider-based designation only transferrable to owner if main provider is sold and new owner accepts assignment of provider agreement
  - Provider-based designation forfeited otherwise
  - Cannot sell clinic alone and maintain provider-based designation

OPPS FINAL RULE
NEW OFF-CAMPUS, PROVIDER-BASED CLINICS/SERVICES/DEPARTMENTS

- Payments to Off Campus Provider Based Departments
  - CMS is adopting Medicare Physician Fee Schedule as applicable payment system
  - Reimbursement will be at 50% of Medicare OP PPS Payment Rate
    - CMS will use claims data to set payment rates by CY 2019
    - Will eventually be the same as “technical component” of PFS Rates
  - Hospital will bill using the hospital UB 04 claim form
    - Use Modifier “PN”
    - Professionals will continue to bill on CMS 1505 for professional services
  - Medicare OP PPS Packaging and Payment Rules will still apply
    - Lab bundled for example
  - Part B drugs still paid at full OPPPS Rates
  - Therapies and preventive services already paid at PFS will not be affected
  - Report billings on Medicare Cost Report to maintain 340B qualification

OPPPS: 2017 FINAL RULE
OFF-CAMPUS, PROVIDER-BASED CLINICS AND SERVICES

Not Applicable to:

- Critical Access Hospitals
  - Off-campus CAH clinics must meet CAH "mileage criteria"
- Medicare-certified Rural Health Clinics
  - Not affected

Other Issues/Comments

- 340b Drug Purchasing Program
  - Off-campus, provider-based clinics can still access 340B pricing
  - Contract pharmacy arrangements

BILLING AND REIMBURSEMENT

PROVIDER BASED CLINICS

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REIMBURSEMENT ISSUES

- Reimbursement Hierarchy
  - Provider Based Clinic - high reimbursement
  - Free Standing Clinic - lowest, generally
- Wild Cards
  - Ancillary Services, provided within clinics (POS)
  - Medicaid payments/reimbursement
    - Medicaid may not recognize PBCs

PAYMENT METHODOLOGIES

Service	Physician Reimbursement	Hospital Reimbursement
• Freestanding Clinic	• Fee Schedule	• All Reimbursement via Physician Fee Schedule
• Provider-Based Clinic	• Fee Schedule (Reduced)	• Cost Based Reimbursement (CAH) • APC

PAYMENT FOR PHYSICIAN SERVICES

Resource-Based Relative Value Scale (RBRVS) Payment Methodology

- Relative Value Unit (RVU) - Separate components for:
  - Work
  - Practice
  - Malpractice
- Each RVU component is updated by a separate Geographic Practice Cost Index (GPCI) for the area.
  - The weighted average of the three GPCIs is called the Geographic Adjustment Factor (GAF)

PAYMENT FOR PHYSICIAN SERVICES

Freestanding Clinic (RI):
CPT-4 Code: 99212

	RVU	GPCI	Product
Work	.48	1.022	.49056
Practice Expense	.70	1.053	.7371
Malpractice	.04	.759	0.03036
			1.25802
Conversion Factor			$35.8279
Medicare Payment	**Part B Services**		**$45.07**

PAYMENT FOR PHYSICIAN SERVICES

Provider Based Clinic (RI):

CPT-4 Code: 99212

	RVU	GPCI	Product
Work	.48	1.022	.49056
Practice Expense	**.19**	1.053	.20007
Malpractice	.04	.759	0.03036
			.72099
Conversion Factor			$35.8279
Medicare Payment	**Part B Services**		**$25.83**

PAYMENT FOR PHYSICIAN SERVICES

Provider-Based Clinic: 99212

		Freestanding	Provider-Based
Charges	Professional Component	$150.00	$45.00
	Facility Charge	NA	$105.00
Total Charges		$150.00	$150.00
Payment for Prof. Service	RBRVS – Medicare Portion	$44.07	$25.83
Hospital Payment for Technical/Facility	Outpatient Prospective Payment System	NA	$102.12

PROVIDER BASED CLINICS: HOSPITAL SUBJECT TO PPS

- Hospital Outpatient Services reimbursed under Outpatient PPS
- Service or Procedure assigned CPT Code
- Code “relates” to or is “assigned” to an APC
  - CPT 99212 = G0463 (Medicare)
  - APC all OP Clinic visits = 06418-002
  - National APC Rate = $102.12

PROVIDER BASED CLINICS: HOSPITAL SUBJECT TO PPS

- Standard Rate, Conversion Factor, set by CMS, multiplied by APC specific weight to yield Payment
- Conversion Factor Updated Annually
- Weights updated and published annually by CMS

CLINICS: PROVIDER BASED AND FREESTANDING CLINICS

SUMMARY TABLE

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PROVIDER-BASED CLINICS VS. FREESTANDING CLINICS

Issue	Freestanding Clinic	Provider-Based Clinic
• Reimbursement	• Based on RBRVS schedule • RBRVS payment is considered final settlement	• Technical/facility Component reimbursement based on APCs (PPS hospitals) or costs (CAH) • RBRVS payment decreased due to reduction in Practice RVU

PROVIDER-BASED CLINICS VS. FREESTANDING CLINICS (CONTINUED)

Issue	Freestanding Clinic	Provider-Based Clinic
• Billing	• All services billed to Part B carrier on CMS1505 • Place of service on CMS1505 is “11” – office	• Two bills will be generated: 1) CMS 1505 for professional services, and 2) UB-04 for technical/facility/ ancillary services • Place of service on CMS 1505 must be a “22” – outpatient hospital • May combine bill “Non-Medicare” patients

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PROVIDER-BASED CLINICS VS. FREESTANDING CLINICS (CONTINUED)

Issue	Freestanding Clinic	Provider-Based Clinic
• Unbundling of Services	• Unbunding of service is NOT prohibited	• Unbunding of services IS prohibited
• Charge Structure	• NA	• Charges for the same procedure (technical) must be consistent between the hospital and the clinic
• Medicare Bad Debts	• Not reimbursable	• Deductibles and coinsurance related to facility charge only • Reimbursable via cost report along with all other Part B bad debts

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PROVIDER-BASED CLINICS VS. FREESTANDING CLINICS (CONTINUED)

Issue	Freestanding Clinic	Provider-Based Clinic
• Coinsurance	• Coinsurance equals 20% of the professional services amount	• Specific amount assigned per APC by CMS; 20% of charge for CAH
• Overhead Allocation	• Allocated hospital O/H is not reimbursable	• Allocation of hospital O/H is included in allowable costs for clinic
• Physician Compensation	• No additional reimbursement for provider component time	• No additional reimbursement for provider component time (except Provider Based RHCs)

PROVIDER-BASED CLINICS VS. FREESTANDING CLINICS (CONTINUED)

Issue	Freestanding Clinic	Provider-Based Clinic
• Certification	• Meet criteria for physician clinic only	• Clinic must meet the same licensure and certification standards as the Hospital

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