What the Medical Services Professional Needs to Know About Provider-Based Practitioners

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What the Medical Staff Professional Needs to Know about Provider-based Practices

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Agenda

- What is provider-based billing?
- What is a provider-based facility?
- What are the financial implications of provider-based status?
- Policy rationale for the provider-based regulation
- What are the requirements for “provider-based” status?
- What are some common pitfalls in complying with provider-based requirements?
- How does Medicare enforce non-compliance & what are the potential penalties?
- Outlook for the future

Medicare: “Complex Regulatory Structure”

“Truth and enlightenment are on another peak. I do medicare explanations.”
Provider-based Billing: 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: Definitions

- Main provider - provider that creates or acquires another entity to deliver additional services in its name, etc.
- Campus - physical area of main buildings and others within 250 yards
- Department of a provider - facility or organization that is created or acquired by main provider to provide services in its name, etc.
- Provider-based entity - separately certified provider owned by main provider (traditional “hospital based” concept) SNF, RHC, etc.
- Remote location of a hospital - another site that furnishes inpatient services
- Freestanding facility - entity that is not provider-based

What Is A Provider-based Facility?

- A facility, located either on or away from a hospital campus, “administered financially and clinically by the main provider,” 65 Fed. Reg. at 18504 (Apr. 7, 2000)
So Why Become Provider-based?

Get paid as a Hospital →

More the same service

Why are Provider-based Charges More?

- Higher hospital overhead and other hospital requirements that freestanding facilities do not need to meet
- Hospital charges (including “facility fee”) are in part cost-based
- CMS rationale
- Support hospitals; support access to care; provide care to needy community segments
- History and development of incentives to become provider-based

Bottom Line: How Much More?

“As an example of payment differences, in 2013, Medicare pays 141 percent more in an OPD than in a freestanding physician’s office for a level II echocardiogram (counting the professional fee and facility fee). In addition, in 2013, Medicare pays 70 percent more in an OPD than in a freestanding office for a 15-minute evaluation and management (E&M) office visit.”

-- Medicare Payment Advisory Commission, June 2013 Report to the Congress: Medicare and the Health Care Delivery System, Ch. 2, Medicare Payment Differences Across Ambulatory Settings (hereafter, “MedPac”) at 31
Bottom Line: cont.

The 340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices.  

http://www.hrsa.gov/opa/340B supports hospitals that serve low-income communities by allowing them to buy drugs at a discount, then sell them to patients at the payer’s regular rate. If the main provider is eligible for the 340B drug discount program, the provider-based facility will be able to participate in the 340B program.

CMS Policy Goals

- Protect beneficiaries & U.S. taxpayers:

  "Our objective in issuing specific criteria for provider-based status is to ensure that higher levels of Medicare payment and increases in beneficiary liability for deductibles or coinsurance (which can all be associated with provider-based status) are limited to situations where the facility or organization is clearly and unequivocally an integral and subordinate part of a provider."

Hospital Industry View

The American Hospital Association disputes the notion that facility fees are a way for cash-strapped hospitals to boost revenue. Outpatient clinics, AHA says, must meet standards that “are more stringent than those governing freestanding doctors’ offices or clinics.” And those clinics have proliferated in order to increase consumers’ access to high-quality care.


Hospitals tend to treat “sicker, more complex patients” and are better equipped than doctors’ offices and should be paid more. Cutting the fees would impact low-income and chronically ill people who depend on networks of hospital-based outpatient clinics, the group said. Hospitals add that charging facility fees for medical care in doctors’ offices or care centers they own helps spread the cost of keeping expensive units, such as emergency rooms, open round the clock, and helps them absorb losses from patients who can’t pay their bills.

-- Center for Public Integrity, Hospital “facility fees” boosting medical bills, and not just for hospital care, Dec. 20, 2012

Patient View

“Until recently, my doctor’s visits were billed for up to $194 per visit. I was therefore perplexed when my last doctor’s visit seemed to be billed twice. One bill, for $194, was for the doctor who saw me at New Mexico Cancer Care clinic. Another bill, for $244, was a facility fee -- for using the space! A facility fee makes no sense to me. A hairdresser does not charge $60 for a haircut and a separate $70 for sitting in the salon, and a dentist does not issue one bill for a filling and another for sitting on a chair. Why should patients and payers pay facility fees for routine office visits?”

-- Orit Tamir, Albuquerque Journal, Letter: Christus St. Vincent facility fee is unfair, unjustified, Nov. 28, 2014

MedPac View

Payment variations across settings urgently need to be addressed because many services have been migrating from physicians’ offices to the usually higher paid OPD setting, as hospital employment of physicians has grown. This shift toward OPDs has resulted in higher program spending and beneficiary cost sharing without significant changes in patient care. From 2010 to 2011, for example, the share of evaluation and management (E&M) office visits provided in OPDs increased by 9 percent, the share of echocardiograms provided in OPDs increased by 15 percent, and the share of nuclear cardiology tests in OPDs increased by 22 percent. If these three types of services continue to migrate to OPDs at the same annual rate from 2011 to 2021, Medicare spending would be $2.3 billion higher per year by 2021, and beneficiary cost sharing would be $590 million higher per year.

-- MedPac at 27-28 (emphasis added)
Enough Already, How Do We Sign-up?

- I Attest: Facilities have the option to seek a determination from CMS that they are provider-based. 42 C.F.R. § 413.65(b)(3).
- But this is not necessary – a facility can bill as provider-based without ever seeking a CMS determination.
  - Note: If no CMS determination is sought, facility has more exposure – i.e., will face higher repayment obligations if a CMS audit later determines the facility not to be provider-based. 42 C.F.R. § 413.65(j); CMS Transmittal A-03-030

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 apply to hospitals/CAHs.

Requirements cont.

- Universal requirements - all facilities or organizations:
  - Common licensure - if allowed by state law.
    - Some states do not permit common licensure of hospital and provider based departments.
  - 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, Quality Assurance, Utilization Review, 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.
Are You Self-Aware?

- “Public Awareness” – crucial!
  - Facility must be unambiguously held out to public as part of the main provider
  - Patients entering the facility must be immediately aware they are entering the main provider & will be billed accordingly
  
  — 42 C.F.R. § 413.65(d)(4)

Provider-based: Clinical Integration

- Clinical Integration – 42 C.F.R. § 413.65(d)(2)
  - Facility staff must have privileges at the main provider***
  - Main provider has identical monitoring and oversight role as it would for any other hospital department
  - Example: Facility medical director must report to CMO at the main provider regarding clinical matters, just as a hospital department head would
  - Main provider’s medical staff committees must be responsible for medical activities in the facility
  - Medical records integrated into a unified retrieval system of the main provider (practitioners in either setting must be able to obtain the medical records from the other setting)
  - Inpatient and outpatient care integrated
  - Patient at the facility who require further care must have access to all hospital resources

Provider-based: Financial Integration

- Financial integration – 42 C.F.R. § 413.65(d)(3)
  - Evidenced by shared income and expenses
  - Costs of the provider-based facility must be integrated into a cost center of the main provider
  - Financial status of the facility readily identifiable in main provider’s trial balance
Integration cont.

- Main provider final responsibility for all administrative decisions — as with all other hospital departments
- Reporting relationship must have the same frequency, intensity and level of accountability that exists between the main provider and one of its departments:
  - Facility directly supervised by main site
  - Same monitoring and oversight as any other hospital department
  - Integrated admin functions: billing, records, HR, payroll, benefits, salary structure, purchasing service
  - Medical director must report to main provider

Integration cont.

- Operation of facility can be contracted out by the main provider; but facility must still meet all the criteria for clinical, financial, and administrative control by main provider
- And: Public Awareness requirements still must be met

Provider-based: Location

- Must be at the hospital, or if “off-campus” (i.e., 250 yards+ away) must meet additional criteria:
  - Not more than 35 miles away
  - Demonstrate that facility serves the same patient population as main provider
    - “75 percent tests:” (e.g., 75% of patients from same zip codes as 75% of the main provider’s patients).
  - Meets all other provider-based criteria
Provider-based: Off-Campus

- Additional off-campus requirements:
  - Constraints on leased employees; management contracts; services provided “under arrangements”
  - Patients must receive clear written notice of additional facility fees 42 C.F.R. § 413.65(g)(7)(ii).
  - Notice of dual coinsurance (facility/technical & professional components) to each Medicare patient before services provided (unless emergent)
  - Facility must be 100% owned by main provider

Off-Campus cont.

- Personnel who are delivering care must be employees of the main provider; cannot be leased employees (management and certain other staff can be leased)
- Administrative functions integrated, and main provider must have significant control over facility’s operations
- Management contract must be held by main provider; cannot be held by a parent of both entities
- Same governing body – 42 C.F.R. § 413.65(e)(1)(iii)
- Facility management must be accountable to the main provider governing body 42 C.F.R. § 413.65(e)(2)
- Same organizational documents – 42 C.F.R. § 413.65(e)(1)(iii)
  - By-laws
  - “Operating decisions of the governing body of the main provider”

Off-Campus cont.

- Main provider has final responsibility for administrative decisions, contracts, personnel actions, personnel policies (including benefits and code of conduct) and final approval for all medical staff appointments – 42 C.F.R. § 413.65(e)(iv)
- Facility director or supervisor/manager must report to the main provider like head of any other hospital department
Provider-based: 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: Obligations

- Treat all Medicare patients as hospital outpatients (facility fee billed on UB-04/1500 with POS 22)
- DRG 3-day payment window applies
- Meet all applicable Medicare hospital conditions of participation – including hospital LSC code!

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)
Provider-based: Recent OIG Focus

**OIG’s 2014 Work Plan**
- Impact of provider-based status on Medicare billing
  - "We will determine the impact of subordinate facilities in hospitals billing Medicare as being hospital based (provider based) and the extent to which such facilities meet CMS’s criteria."
- Comparison of provider-based and free-standing clinics (new)
  - "We will review and compare Medicare payments for physician office visits in provider-based clinics and free-standing clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on the Medicare program of hospitals’ claiming provider-based status for such facilities."

**OIG’s 2015 Workplan:**
- Medicare oversight of provider-based status
  - "We will determine the extent to which provider-based facilities meet CMS’s criteria."
  - "In 2011, the Medicare Payment Advisory Committee (MedPAC) expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services."
- Comparison of Provider-based and Free-Standing Clinics

**Provider-based – OPPS 2014**
- Payment change for hospital outpatient departments for CY 2014
  - CMS collapsed the 5 levels of visit codes for both new and established patients into 1 code for facility payment (G0463)
  - Single level of payment for all outpatient clinic visits except for emergency room visits
  - MedPAC strikes again: recent proposal to reduce payment for services in 66 APCs to more closely mirror payment under the MPFS
Billing Modifier for CY 2016

- CMS Final Rule for CY 2015 finalized proposals related to reporting of data for services provided in hospital off-campus provider-based departments (PBDs)
- Intent is to capture outpatient services furnished at the hospital’s main campus and off of any other hospital campuses
- New HCPCS modifier “PO” is required on the UB (hospital claim) for each outpatient hospital service furnished in an off-campus PBD.
- Voluntary reporting beginning January 1, 2015 with required reporting by January 1, 2016

Billing Modifier for CY 2016

- For professional claims (1500 form), place of service code (POS) 22 (outpatient department) will be deleted and replaced with two new POS codes:
  - one to identify outpatient services furnished in on-campus, remote, or satellite locations of a hospital; and
  - one to identify services furnished in an off-campus PBD
- POS 23 (emergency room) will not change
- The new POS codes will be required to be reported as soon as they become available which is not expected before July 1, 2015

And the Focus is Getting Traction

- State attorney general interest
- U.S. Congressional interest (Sen. Grassley, incoming chair of Senate Judiciary Committee, and senior member of Senate Finance Committee)
- Significant industry groups supporting elimination of provider-based billing (e.g., American College of Physicians, May 2013 letter to Senate Finance)
State law?

- Note: We’ve only discussed federal law, regulation and requirements. Some states have additional provider-based rules. Let’s be careful out there!

Outlook:

- Not going away anytime soon, due to influence of the hospital lobby – but due to the recent rise in acquisitions of physician practices by hospitals, the MedPac-led argument that the U.S. taxpayer should not be required to pay more for the same services based on a technicality is gaining ground, and the safest conclusion is that the days are numbered
- Maybe grandfathered?

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