Auditing Your Hospital’s Provider-Based Status

Key Requirements, Internal Audit Perspective, and the Latest Developments

December 3, 2015

Why talk about compliance with provider-based status and the regulatory issues?
Agenda

- What is provider-based status?
- How does it impact my facility?
- Who do the regulations apply to?
- What are the requirements for provider-based status?
- When did provider-based status regulation begin, and how have they changed?
- How do we gauge compliance with regulations when performing an internal audit?
- What are the key regulatory changes and rulings?

Provider-based status background

What is provider-based status and how does it impact my facility?

- Provider-based status signifies a relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility

- Provider-based status affects the manner in which services are billed to Medicare and Medicaid:
  - The location bills as part of the main provider to which it is provider-based:
    - The professional claim (for physician services) is billed on CMS 1500 with the appropriate site of service (21 for hospital inpatient or 22 for hospital outpatient)
    - The technical claim (for hospital services) is billed on UB-04
Provider-based status background (continued)

What is provider-based status and how does it impact my facility?

- Potential Advantages:
  - Higher reimbursement amounts
  - Technical and professional fees
  - 340B drug discount program eligibility
  - Inclusion in the main provider’s third party payer contracts

- Perceived Disadvantages:
  - Medicare Condition of Participation applies
  - Emergency Medical Treatment and Active Labor Act
  - Written notice to beneficiaries required for off campus facilities
  - Patient confusion (e.g., receiving multiple bills for one visit/encounter)

Who do the regulations apply to?

- Regulations apply to:
  - On campus facilities*:
    - Within 250 yards of the main provider
  - Off-campus facilities:
    - Within 35 miles of the main provider (more than 35 miles considered remote off-campus)
  - Multi-campus facilities

- Who is considered a provider*:
  - Hospitals and CAH’s that either create or acquire ownership of another entity to deliver additional health care services under its name, ownership, and financial and administrative control

* Only a subset of the regulations apply
## Provider-based status background (continued)

### What are the requirements for provider-based status?

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<th>Note</th>
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<td>Financial Integration</td>
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### How did we get here?


- A final rule published in August 2002 revised the 42 CFR § 413.65 regulation, effective October 1, 2002 or July 1, 2003, dependent on grandfathered status.

- In April 2003, a Program Memorandum (Transmittal A-03-030) was issued to provide additional guidance on the revised regulations.

- Ultimately, § 413.65 was amended to effectively apply to only Hospitals and Critical Access Hospitals (CAH).
How do we gauge compliance when performing an internal audit?

Internal audit areas of focus – all facilities

*Have actions been taken to promote compliance with the regulations?*

<table>
<thead>
<tr>
<th>Area of Regulation</th>
<th>What Actions are We Looking For?</th>
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</table>
| **Clinical Integration** | • Main provider maintains the same oversight over the provider-based facility  
• Medical records are integrated with the main provider  
• A physician or non-physician practitioner provides direct supervision of therapeutic and diagnostic services at the facility                                                                                                     |
| **Financial Integration** | • The financial operations of the facility are fully integrated into the financial system of the main provider  
• Facility costs are reported in a cost center(s) of the main provider  
• The facility’s financial status is incorporated and readily identified in the provider’s trial balance                                                                 |
| **Public Awareness**     | • The facility’s name and signs clearly indicate that it is an outpatient department of the main provider  
• The facility uses the same uniforms and badges for its employees as the main provider used for its employees  
• References to the facility on the website of the main provider clearly indicate the facility is part of the main provider  
• The facilities billing letterhead clearly states that the facility is part of the main provider                                                                 |
Internal audit areas of focus – off-campus

Have actions been taken to promote compliance with the regulations?

<table>
<thead>
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<th>Area of Regulation</th>
<th>What Actions are We Looking For?</th>
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</table>
| Administration & Supervision | • The facility is under the direct supervision of the main provider  
• The facility is operated like any other department of the main provider with regard to supervision and accountability and the same reporting relationships exist  
• Billing services, medical records, human resources, payroll, employee benefit package, salary structure, and purchasing services for the facility are integrated with those of the main provider |

| Notice to Medicare Beneficiaries | • Before the delivery of services, the facility provides written notice to Medicare beneficiaries of the amount of the beneficiaries potential financial liability. Notice also states that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service (including the amount). |

Internal audit areas of focus – adjacent to other provider

Have actions been taken to promote compliance with the regulations?

• “Shared Space” is a hot topic

• Internal audit can assess whether:
  • Separate registration areas/windows exist or a shared area/window is clearly designated
  • Separate entrances/exits exist, or if shared, clearly identify the clinical space used by the main provider at the facility
  • Separate waiting rooms exist, or if shared, clearly identify the clinical space used by the main provider at the facility
  • Separate hallways are used to take patients from waiting rooms to clinical areas at the facility. If hallways are shared, signs clearly identify the space used by the main provider at the facility.
  • Separate recovery rooms are used at the facility for outpatients of the main provider
  • The clinical space used by the main at the facility is not shared with other providers, unless the other provider uses a site-of-service modifier when seeking reimbursement for their services
How are main providers monitoring compliance?

*Example of a checklist used at a main provider to promote compliance with provider-based status regulations*

### A. Clinical Services Integration - 42 C.F.R.§413.65(d)(2)

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<tr>
<td>1.</td>
<td>All professional services provided at the facility must be performed by members of the Hospital’s medical staff.</td>
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<tr>
<td>2.</td>
<td>The Hospital maintains the same monitoring and oversight of the facility as it does for any other Hospital department.</td>
</tr>
<tr>
<td>3.</td>
<td>The medical director of the facility maintains a reporting relationship with the Hospital’s chief medical officer that is equal in frequency, intensity and accountability as any other medical director.</td>
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<tr>
<td>4.</td>
<td>The medical staff of the Hospital is responsible for the medical activities conducted at the facility (e.g., credentialing, peer review).</td>
</tr>
<tr>
<td>5.</td>
<td>Medical records for patients treated in the facility are integrated with those of the main Hospital.</td>
</tr>
<tr>
<td>6.</td>
<td>The inpatient and outpatient services between the Hospital and the facility are integrated.</td>
</tr>
<tr>
<td>7.</td>
<td>A physician (doctor of medicine or osteopathy, dental surgery or medicine, doctor of pediatric medicine, doctor of optometry and chiropracter) provides direct supervision of diagnostic services provided at the facility.</td>
</tr>
<tr>
<td>8.</td>
<td>A physician or non-physician practitioner (physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives and licensed clinical social workers) provides direct supervision of therapeutic services provided at the facility.</td>
</tr>
<tr>
<td>9.</td>
<td>The Hospital and facility have an integrated performance improvement program, and the Hospital retains the authority necessary to implement performance improvement actions at the facility.</td>
</tr>
<tr>
<td>10.</td>
<td>The facility is not restricted to Hospital associated physician groups.</td>
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**How are main providers monitoring compliance?** *(cont.)*

*Example of a checklist used at a main provider to promote compliance with provider-based status regulations*

### B. Financial Integration - 42 C.F.R.§413.65(d)(3)

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>The financial operations of the facility are fully integrated within the financial system of the main Hospital. The costs of the facility are reported in a cost center(s) of the main hospital, and the financial status of the facility is incorporated and readily identified in the hospital’s trial balance.</td>
</tr>
<tr>
<td>2.</td>
<td>A business plan for the facility was completed and approved by the Hospital, as required by Hospital policy.</td>
</tr>
<tr>
<td>3.</td>
<td>A funds flow agreement was entered into by the Hospital with Provider Groups with respect to the facility.</td>
</tr>
<tr>
<td>4.</td>
<td>A written lease regarding shared space at the facility exists that, prior to execution, was reviewed by the Legal and Risk Services Department for compliance with regulatory requirements, or the Legal and Risk Services Department determined that no such lease was necessary.</td>
</tr>
<tr>
<td>5.</td>
<td>A written professional services agreement exists that, prior to execution, was reviewed by the Legal and Risk Services Department for compliance with regulatory requirements, or the Legal and Risk Services Department determined that no such agreement was necessary.</td>
</tr>
<tr>
<td>6.</td>
<td>A written employee lease exists that, prior to execution, was reviewed by the Legal and Risk Services Department for compliance with regulatory requirements, or the Legal and Risk Services Department determined that no such lease was necessary.</td>
</tr>
<tr>
<td>7.</td>
<td>A written equipment lease exists that, prior to execution, was reviewed by the Legal and Risk Services Department for compliance with regulatory requirements, or the Legal and Risk Services Department determined that no such lease was necessary.</td>
</tr>
</tbody>
</table>
How are main providers monitoring compliance? (cont.)

Example of a checklist used at a main provider to promote compliance with provider-based status regulations

<table>
<thead>
<tr>
<th>C. Public Awareness - 42 C.F.R. §13.65(d)(4)</th>
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</thead>
<tbody>
<tr>
<td>1. The name of the facility clearly indicates that it is an outpatient department of the Hospital.</td>
</tr>
<tr>
<td>2. Signs clearly identify the facility as part of the Hospital.</td>
</tr>
<tr>
<td>3. The Hospital uses the same uniforms and badges for the employees that it assigns to the outpatient facility as it does for employees in the main building. Employees who register Hospital outpatients at the facility wear Hospital uniforms and badges.</td>
</tr>
<tr>
<td>4. The billing letterhead and accompanying materials, such as explanation of charges, clearly state that the facility is treated as part of the Hospital.</td>
</tr>
<tr>
<td>5. Brochures and advertising for the facility, if any, explain that the facility is treated as part of the Hospital.</td>
</tr>
<tr>
<td>6. References to the facility on any Hospital-controlled websites clearly state that the facility is considered to be part of the Hospital.</td>
</tr>
</tbody>
</table>

Regulatory changes & rulings
Bipartisan Budget Act of 2015

Will there be no new off-campus hospital outpatient departments?

• Signed into law by President Obama on November 2, 2015

• Beginning January 1, 2017, establishes a prohibition on newly created off-campus hospital outpatient departments from receiving provider-based Medicare reimbursement for non-emergency services

• Revises the hospital Outpatient Prospective Payment System (OPPS):
  - Off-campus facilities prohibited from reimbursement under the OPPS
  - Services provided by off-campus facilities will be reimbursed under Medicare physician fee schedule or other applicable reimbursement methodology

• Exemptions: “dedicated emergency departments” and existing off-campus hospital departments:
  - Existing off campus hospital departments defined as “billing under [the hospital OPPS] with respect to covered [outpatient department] services furnished prior to the date of the enactment of this paragraph.”

OIG FY16 work plan

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**Medicare Part A and Part B**

*Hospital-Related Policies and Practices for Provider-Based Status*

**REVISED:** Medicare oversight of provider-based status

• Determine the number of provider-based facilities that hospitals own and the extent to which CMS has methods to oversee provider-based billing. We will also determine the extent to which provider-based facilities meet requirements described in 42 CFR Sec. 413.65 and CMS Transmittal A-03-030, and whether there were any challenges associated with the provider-based attestation review process. Provider-based status allows facilities owned and operated by hospitals to bill as hospital outpatient departments.

• Context—Provider-based status can result in higher Medicare payments for services furnished at provider-based facilities and may increase beneficiaries’ coinsurance liabilities. The Medicare Payment Advisory Commission (MedPAC) has expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. (OEI; 04-12-00380; expected issue date: FY 2016) (emphasis added)

**HOLD-OVER:** Comparison of provider-based and freestanding clinics

• Review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the difference in payments made to the clinics for similar procedures and assess the potential impact on Medicare of hospitals’ claiming provider-based status for such facilities.

• Context—Provider-based facilities often receive higher payments for some services than do freestanding clinics. The requirements to be met for a facility to be treated as provider based are at 42 CFR § 413.65(d). (OAS; W-00-14-35724; W-00-15-35724; expected issue date: FY 2016)
Provider-based settlements in the headlines

• A hospital in the Midwest agreed to a settlement of $2.63 million with the OIG as a result of improperly submitted claims
  o Claims were submitted to Medicare, Medicaid, and TRICARE for hyperbaric oxygen therapy services
  o The services did not satisfy provider-based requirements and were self-disclosed under a corporate integrity agreement

• A hospital in the Northeast agreed to pay $3.37 million to settle false claim allegations
  o The allegations were in regards to improperly billed Medicare provider-based services

Source: http://aishealth.com/archive/040615-01
Resources and links

- http://aishealth.com/archive/rmc040615-01
- https://www.law.cornell.edu/cfr/text/42/413.65
- https://www.healthlawyers.org/Archive/PG/Toolkits/Provider-Based%20Toolkit/5_Checklist.pdf
- http://www.hcca-info.org/Portals/0/PDFs/Resources/Conference_Handouts/Compliance_Institute/2014/Pre/P9Handout3.pdf

Contact information