Provider-Based Status Compliance: Space Sharing and Reimbursement Charges

Presentation by

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Provider-Based Status
What is It and How to Qualify?
Provider-Based Basics

What does it mean for a location to be provider-based?

- A Medicare designation that allows hospitals to treat certain departments and facilities located outside of the hospital as part of the hospital for billing purposes
- Services furnished in a location meeting provider based requirements are covered by Medicare as hospital outpatient services
- Exception for non-OPPS services (physical, occupational, and/or speech therapy)
On-Campus vs Off-Campus

On-campus locations are:

- Buildings or structures within 250 yards from main building
- Measure “as the crow flies”
- CMS Regional Office has discretion to determine on campus on case-by-case basis

Off-campus locations are:

- Not on the main campus or 250 yards from main building or a “remote location” of the hospital
- Provider-based to main provider
- Not a joint venture, not RHC or FQHC
Requirements for On-Campus and Off-Campus Locations

- **Licensure**
  - Main provider and location must be licensed under the same license under state law and each outpatient location must be accredited as a hospital outpatient department (Note: Ohio does not license hospitals)
Requirements for On-Campus and Off-Campus Locations

Clinical Integration

- All clinical services of main provider (hospital) and location must be integrated by:
  
  • Professional staff must have privileges at main provider
  • Main provider maintains same monitoring and oversight at location as does for other departments of main provider
  • Location medical director must report to main provider chief medical officer and be supervised as are other medical directors
  • Main provider medical staff and professional committees must be responsible for location activities
Requirements for On-Campus and Off-Campus Locations

- **Clinical Integration** (continued)
  - Medical records of location must be integrated into unified retrieval system with main provider so that each site can retrieve records of other
  - Inpatient and outpatient services of two locations must be integrated to provide patients of location with access to all services of the main provider
Requirements for On-Campus and Off-Campus Locations

- Financial Integration
  - Main provider and location’s financial operations must be fully integrated within the financial system of the main provider
  - Must have shared income and expenses
  - Requires location’s costs and revenue to appear on the main provider’s cost report as a cost center and location is incorporated into main provider’s trial balance
Requirements for On-Campus and Off-Campus Locations

- **Public Awareness**
  - Location must be held out to public as part of the main provider
  - Patients entering the location and receive services they must be aware they are in a department of the main provider (and not a physician office or other non-main provider site)
  - Signage, marketing materials, patient handouts, telephone number and listings, etc. all need to indicate location is part of main provider
Requirements for On-Campus and Off-Campus HOPDs

- Hospital outpatient departments (HOPDs) must comply with:
  - EMTALA antidumping rules (on-campus and off-campus dedicated emergency departments)
  - Medicare hospital conditions of participation
  - Provider agreement
  - Nondiscrimination requirements
  - Billing physician services using correct site of service (POS Code 22- On-Campus Hospital Outpatient)
  - 3-day payment window
  - Advanced beneficiary notice
Additional Requirements for Off-Campus Locations

Ownership and Control

– Location 100% owned by main provider
– Location and main provider share governing body
– Location and main provider operate under same organizational documents
– Main provider retains financial responsibility for administrative decisions (contract approvals, personnel policies, final approval of medical staff appointments)
Additional Requirements for Off-Campus Locations

- Administrative and Supervision
  - Off-campus location must be under same control as main provider
    - Under direct supervision of main provider
    - Off-campus location director must report to manager at main provider and be accountable to main provider’s governing body
    - Administrative functions (billing, HR, medical records) must be integrated with main provider or contracted under same agreement or under separate agreements maintained by main provider
Additional Requirements for Off-Campus Locations

- **Distance from Main Provider**
  - Off-campus location must be within a 35-mile radius of the main provider unless meets alternative test
  - Alternative test 75 percent patients in same zip code (i.e., do they serve same population) or DSH hospital
  - Measure “as the crow flies” from main provider
  - Both main provider and off-campus location must be physically located in the same state or two adjacent states whose laws permit the arrangement to cross state lines, such as using a reciprocal agreement
Billing at Off-Campus PBDs

- New modifier and Place of Service (POS) Code for claims for Off-Campus PBDs mandatory as of January 1, 2016 to track off-campus PBDs
  - Modifier- PO “Services, procedures, and/or surgeries furnished at off-campus PBDs” for all HCPCS codes for items or services furnished at off-campus PBDs
    - Critical access hospitals (CAHs), remote locations, satellite facilities and emergency departments excluded
  - Physician claims in off-campus PBDs use new POS Code 19 - Off Campus Outpatient Department; revised POS Code 22 - On-Campus Outpatient Hospital
Attestation

- Compliance with all provider-based requirements is mandatory, but attestation is voluntary.
- Provider-based status is effective on the earliest date the location and main provider meet the provider-based requirements.
- To obtain CMS’ determination that a location meets the provider-based requirements, the provider must submit an attestation stating it meets all requirements.
Penalties for Non-Compliance

- Failure to comply with provider-based requirements exposes the main provider to:
  - Overpayment liability
  - False Claims Act liability
  - Amount of overpayment equals payment differential between provider-based and non-provider-based reimbursement at location (e.g., OPPS versus physician office)
Pros and Cons of Provider-Based Status

- **Pros**
  - OPPS reimbursement
    (if grandfathered or until 1/1/17)
  - Included in main provider payor contracts
  - 340B drug discount program eligibility
  - Main provider DSH and IME payments
  - Count residents for GME/IME payments
  - Medicare bad debt payments
Pros and Cons of Provider-Based Status

Cons
- Facility fee and physician fee (duplicate co-insurance)
- Physician/patient dissatisfaction
- Regulatory compliance and evolving regulations
340B Program and Provider-Based Status
340B Program and Provider-Based Status

- Hospitals must qualify as “covered entities” to purchase drugs under 340B program
- HRSA requires 340B drugs to be dispensed in a location submitted on the covered entity’s cost report as provider-based
- Patient must qualify as a hospital OP when receiving the order or prescription
- Patient must be receiving professional services in a hospital OP department from a contracted physician
Section 603 of Bipartisan Budget Act of 2015
Bipartisan Budget Act of 2015, Section 603

- As of 1/1/17, no off-campus hospital outpatient department (OC-HOPD) may bill under OPPS unless:
  1. It is a “dedicated emergency department” (DED) or
  2. It is grandfathered

- After 1/1/17, the non-grandfathered OC-HOPD will need to bill under another payment system
  - MPFS
  - ASC
Definitions

- **Campus**
  - Physical area immediately adjacent to provider’s main buildings
  - Buildings or structures not immediately adjacent but within 250 yards from main building
  - Any other areas determined on an individual case basis by the CMS regional office
Definitions (continued)

- **DED:** Must meet at least one of the following:
  - State licensure as an emergency room or emergency department
  - Holding out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring an appointment; or
  - Provision of at least one-third of all of outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment
Grandfathering of Existing Off-Campus Hospital Outpatient Department

- How does OC-HOPD get grandfathered?
  - If the “department of a provider . . . was billing under [OPPS] with respect to covered OPD services furnished prior to the date of the enactment of this paragraph”
  - President signed BBA 2015, November 2, 2015
Judicial Review Preclusion

- No administrative or judicial review of:
  - Whether the services furnished are services of a dedicated emergency department
  - Whether a provider-based clinic is off-campus or on-campus
  - Whether a provider-based clinic benefits from grandfathered status

- Unclear if any removal of existing provider-based status will continue to be appealable
Bipartisan Budget Act 2015

- Possible amendment?
  - Mid-build exception
  - Cancer center exception

- Narrowly tailored
Shared Space Issues
Space Layout Issues

- Hospital outpatient department/non-hospital provider/supplier shared space arrangements
  - Provider-based status final rule

- Different types of shared space arrangements
  - Time share arrangement
  - Time block arrangement
  - Suites within medical office building
  - Shared reception/waiting area
New Thinking on Co-Location

- July 2011 CMS Letter
- May 5, 2015 David W. Eddinger AHLA Webinar
- Spring 2015 CMS training of:
  - Accrediting Agencies (e.g., Joint Commission)
  - State Survey Agencies

November 2015 Montana Hospital Revocation of provider-based status
Co-Location Principle

- General principle:
  - All certified hospital space, departments, services, and/or locations must be 100% hospital usage 24/7
  - “Hospitals are not permitted to “carve-out” areas as non-hospital space”
  - Cannot be “part time” of the hospital and “part time” another hospital, ASC, physician office, or any other activity
  - Flagged co-location with physician offices as issue
  - CoP and provider-based violations at risk
Co-Location Principle

- Sufficiently separated space is “indicated by”:
  - Exclusive:
    - Entrance
    - Waiting
    - Registration areas
    - Permanent walls
    - In MOBs, distinct USPS designations
Co-Location Principle

“indications that a purported hospital space may instead be a part of a larger component”:

– Shared entryway
– Interior hallways
– Bathroom facilities
– Treatment rooms
– Waiting rooms and
– Registration areas
Revocation for Shared Space

- Montana Hospital’s off-campus physician clinics provider-based status revoked
- Visiting specialists with timeshare lease in provider-based space
- Appealed
Shared Space Example 1

- Hospital opens a provider-based cardiology diagnostic testing center in Suite D of its MOB.
- All other Suites have independent physician practices.
- Hospital staff register patients for the cardiology diagnostic testing.
Shared Space Example 2

- Hospital A buys radiology equipment from Physician B. The equipment is located in the lower level of a building owned by Physician. Main floor divided into ASC and physician office. Enter main door walk straight to registration for physician office. Walk right down a hall to elevator to go to lower level.
Example 2

ASC

Physician Office

Parking

Elevator to LL

Reg. Desk

Wall

Waiting

Parking
Shared Space Example 3

- Hospital B buys radiology equipment that is located in Physician Y’s office. The radiology space is separated from the physician office by a door. Hospital and Physician office patients register at the same registration desk but a different sign in sheet. The hospital patient would be escorted back to the radiology area to wait in the radiology area waiting room.

- Is this enough separation?
Shared Space Example 4

- Hospital acquires a physician practice. The physician owned a CT scanner and it was placed in a separate room inside the physician’s office suite.
- The Hospital made the CT scanner “provider-based”.
- The physician office staff registered patients for the CT scans.
- The Hospital CT scan patients and the physician office patients share a waiting room.
Shared Space Example 5

- Multi use building/open floor plan. Physician Practice A has Pod 1 for urgent care services and Pod 3 for private practice services. Pod 2 is Hospital’s B’s imaging and blood draw services.

- Pod 1 is on the right, Pod 3 is on the left and Pod 2 is in the back. As patient’s enter they would register for one of the three services.

- Each Pod would have its own staff, separate telephone number and separate mailbox area. Mail is delivered to building address and separated internally.

- Signage would be outside and inside indicating where the services are located and who the provider is.
Example 5
Shared Space Example 6

- Hospital operates a provider-based clinic in an MOB.
- Different specialists come in and see patients during the week.
- Employed physicians are billed as provider-based (split billed).
- Independent physicians time-share one or two exam rooms (Tues/Thurs) and bill “private office”.
Example 6
Questions?

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