Provider-Based Status

Presented by:
Trudy Struck
trudystruck@blueandco.com
317.713.7947
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Today’s Agenda

Provider-Based Status

- Overview
- Definitions
- Requirements
- Additional Provisions
- Obtaining Provider-Based Determination
- Hospital Obligations
- Inappropriate Provider-Based Treatment
- Physician Supervision
Overview

Background

- Regulations in 42 CFR 413.65 (Effective October 2002) describe criteria and procedures for determining whether an organization is provider-based.
- CMS has permitted the subordinate facility to be considered provider-based. The determination of provider-based status allowed the main provider to share overhead costs, which were allowed to flow to the subordinate facility through the cost allocation process in the cost report. The facilities were operationally integrated, and provider-based facility was sharing overhead costs and revenue producing services controlled by the main provider.
Definitions

Provider-Based

- **Campus** – the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings.

- **Main provider** – a provider that either creates, or acquires ownership of another entity to deliver additional healthcare services under its name, ownership, and financial and administrative control.

- **Department of a Provider** – a facility, organization or clinic that is either created by, or acquired by, a main provider for the purpose of furnishing healthcare services under the name, ownership, and financial and administrative control of the main provider.
Definitions (Cont.)

Provider-Based

- **Free-Standing Facility** – an entity that furnishes healthcare services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, department of a provider, or a provider-based entity.

- **Satellite Facility** – part of a hospital (or of a hospital unit) that provides services in a building also used by another hospital or in one or more buildings on the same campus as buildings also used by another hospital.
Provider-Based Requirements

Provider–Based Entity or Department of Provider

- The following criteria must be met for on-campus facilities or organizations:
  1. Licensure
  2. Accreditation
  3. Clinical Services
  4. Public Awareness
  5. Financial Integration

- In addition to the above noted criteria, the following are applicable to off-campus facilities:
  1. Location in Immediate Vicinity
  2. Ownership and Control
  3. Administration and Supervision
Provider-Based Requirements

Location in Immediate Vicinity

- Facility or organization and the main provider are located on the same campus or within 35 miles of each other.
- Effective January 1, 2008, CAHs may not acquire a NEW off-campus facility and treat, bill and receive cost reimbursement as provider-based unless the off-site is located more than 35 miles from another CAH or hospital. RHCs are excluded from the CAH provider-based distance requirement.
- High level integration – facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the main provider.
Provider-Based Requirements

Location in Immediate Vicinity (Cont.)

- Must submit records showing that during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent period:
  - At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider; or
  - At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider; or
  - If the facility or organization is unable to meet the criteria because it was not in operation during all of the 12-month period, the facility or organization is located in a zip area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the main provider.
Provider-Based Requirements

Located in Immediate Vicinity (Cont.)

- **Same State or Adjacent State** – a facility or organization is not considered to be in the “immediate vicinity” of the main provider unless the facility or organization and the main provider are located in the same state or, in adjacent states where there is consistency within the laws of both states.

- **RHC** – an RHC otherwise qualified as a provider-based entity of a hospital that is located in a rural area and has fewer than 50 beds is not subject to the criterion.
Provider-Based Requirements

Licensure

- Department of the provider, remote location of the hospital, or satellite facility and the main provider are operated under the same license, except in areas where the state requires a separate license or in states where state law does not permit licensure under a single license.

- In Indiana, the additional location is added as an addendum to the hospital license.

- The additional location must be added to the Medicare Legacy Provider for Medicare certification.
Provider-Based Requirements

Accreditation

- The facility seeking provider-based status must be included under the accreditation of the main provider and the accrediting body has recognized the facility as part of the main provider.
Provider-Based Requirements

Ownership and Control

- The facility seeking provider-based status must be operated under the ownership and control of the main provider and common governance. The following requirements must be met:
  - The business enterprise that constitutes the facility or organization must be 100 percent owned by the main provider.
  - The main provider and the facility seeking provider-based status as a department of the provider, remote location or satellite facility are subject to common bylaws and operating decisions of the same governing body.
  - The facility must be operated under the same organizational documents as the main provider.
  - The main provider must have final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies, and final approval for medical staff appointments in the facility or organization.
provider-based requirements

administration and supervision

- reporting relationship between facility or organization seeking provider-based status and the main provider must have the same frequency, intensity and level of accountability that exists in the relationship between the main provider and one of its departments, as evidenced by compliance with all of the following requirements:
  - under the direct supervision of the main provider.
  - monitored by the main provider as any other department of the provider and is operated just as any other department of the provider with regard to supervision and accountability.
  - administrative functions of the facility are integrated with those of the main provider.
Provider-Based Requirements

Clinical Services

- Professional staff of the facility has clinical privileges at the main provider.
- Main provider maintains the same monitoring and oversight of the facility as it does for any other department of the provider.
- Medical director of the facility seeking provider-based status maintains day-to-day reporting relationship with the chief medical officer or other similar official of the main provider and is under the same supervision as any other medical director of the main provider.
- Medical staff committees or other professional committees at main provider are responsible for medical activities in the facility.
- Medical records for patients treated in the facility are integrated into a unified retrieval system of the main provider.
- Inpatient and outpatient services fully integrated.
Provider-Based Requirements

Public Awareness

- Facility seeking status as department of a provider, remote location or satellite facility is held out to the public and other payors as part of the main provider.

Financial Integration

- Financial operations of the facility or organization must be fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization.
Additional Provisions

Joint Ventures

- In order for a facility operated as a joint venture to be considered provider-based, it must:
  1) Be partially owned by at least one provider
  2) Be located on the campus of a provider who is a partial owner
  3) Be provider-based to that one provider whose campus on which the facility or organization is located
  4) Meet all of the requirements applicable to all provider-based facilities and organizations
Additional Provisions

Management Contracts

- Will not apply to on-campus facilities so long as all other applicable requirements for provider-based are met.
- Facilities operated under management contracts are considered provider-based if all of the following criteria are met:
  - Non-management staff of the facility or organization are employed by the provider or by another organization other than the management company.
  - Administrative functions of the facility or organization are integrated with those of the main provider.
  - Main provider has significant day-to-day control over operations of the facility or organization.
  - Management contract is held by main provider itself.
  - Main provider employs the staff of the facility or organization who are directly involved in the delivery of patient care.
  - Other than staff that may be paid under a Medicare fee schedule, main provider may not utilize the services of leased employees who are directly involved in patient care in off-campus facilities.
Responsibility for Obtaining Provider-Based Determinations

Provider-Based Attestations

- Attestation and written documentation of provider-based status must be on file with the main provider.
  - Attestation to include identity of the main provider and the facility or organization for which provider-based status is being sought and supporting documentation.
  - Provider must enumerate each facility and state its exact location and the date on which the facility became provider-based to the main provider.
Obligations of Hospital Outpatient Departments and Hospital-Based Entities

Requirements

- Hospital outpatient departments located either on or off the main premises of the hospital must comply with anti-dumping rules.
- Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service indicator.
- Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with non-discrimination provisions.
Obligations of Hospital Outpatient Departments and Hospital-Based Entities

Requirements (Cont.)

- When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC), the hospital has a duty to notify the beneficiary, prior to the delivery of services, of the beneficiary’s potential financial liability (that is, a coinsurance liability for an outpatient visit to the hospital as well as for the physician service).
Inappropriate Treatment
As Provider-Based

Determination and Review

- If CMS learns of a provider treating a facility as provider-based without notification to obtain a determination of provider-based status, the following actions will be taken:
  - All payments to that provider for all cost reporting periods subject to re-opening will be reconsidered.
- In cases where the facility or organization would not qualify for a provider-based determination, CMS will recover the difference between the amount of payments that actually were made and the amount of payments that should have been made in the absence of a determination of provider-based status.
Physician Supervision

Requirements

- Medicare covers outpatient hospital services and supplies furnished incident to a physician service. To be covered as “incident to” physicians’ services, the services and supplies must be furnished on a physician's order by hospital personnel under hospital medical staff supervision in the hospital, or if outside the hospital, under the direct supervision of a physician.

- “Direct supervision” means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed. The supervising physician does not have to be of the same specialty as the procedure or service that is being performed.
Physician Supervision

Requirements (Cont.)

- The direct supervision requirement is separate from and independent of the provider-based requirements. Hospitals are already subject to the direct supervision of “incident to” services requirement per the Medicare Hospital Manual, Pub. 10, Section 230.4A.

- When outpatient services are provided at a location off the campus of the hospital, the physician (MD, DO) must be present and on the premises of the location and immediately available to furnish assistance and direction. This applies to services furnished at an entity designated as having provider-based status as a department of a hospital. Effective January 1, 2010, CMS expanded the supervisory rules to include the clinical psychologist, nurse practitioner, physician assistant, nurse midwife, and licensed clinical social worker.
References

Code of Federal Regulations:

- Requirements for a determination that a facility or an organization has provider-based status, 42 CFR, Section 413.65.
Disclaimer

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Questions?
Contact Information

Trudy Struck

tstruck@blueandco.com

317.713.7947