Provider-Based Status Update:
How Recent Changes Impact Off-Campus Outpatient Departments

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Provider-Based Status: What is it?

- Location is treated as part of the main hospital
- CMS will treat a location as part of the hospital, and pay for services under OPPS, only when the hospital maintains control over the quality of care and finances of the location
- Allows the location to qualify for 340B program
- Allows the location to be included in the main provider’s third party payor contracts
- Numerous requirements to qualify at 42 CFR 413.65
- Voluntary attestation to CMS that the location meets requirements
- CMS approval of the location as provider-based eliminates the risk of retrospective recoveries
On Campus vs. Off Campus

- Campus as defined in Provider-Based Rule:
  - Physical area immediately adjacent to provider’s main buildings
  - Other areas and structures not strictly contiguous to the main buildings but within 250 yards of the main buildings
  - Any other areas determined on an individual case basis to be part of the main campus by the CMS Regional Office
Background Leading Up to Recent Changes in Provider-Based Rules

- Growth in hospital purchases of physician practices and integration of practices as HOPDs
- Total Medicare payment for service in a HOPD is generally higher than total payment for the same service in a physician office (two claims) and can increase Medicare beneficiary copayments
- Claim “PO” modifier to identify services furnished in OC-HOPD within claims data mandatory 1/1/16, but does not distinguish between multiple OC-HOPDs of same hospital
Bipartisan Budget Act of 2015, Section 603

- Bipartisan Budget Act of 2015 signed into law November 2, 2015
- Section 603 of the Budget Act was applicable to Provider-Based Departments
- 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 excepted/grandfathered
- After 1/1/17, non-excepted OC-HOPDs will need to bill under another payment system
• DED defined by EMTALA definition:
  − State license as an emergency room or emergency department
  − Held out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring an appointment; or
  − Provides at least one-third of all of outpatient visits for the treatment of emergency medical conditions

• **ALL** services at DED (not just emergency services) are exempt from the Budget Act changes
Other Entities/Locations NOT Affected by Budget Act

- On-campus HOPDs
- Provider-based entities (such as rural health centers) – only applies to provider-based departments
- Facilities not billed under OPPS
Statutory Exceptions from Site-Neutral Payments for Provider-Based Locations

• Excepted OC-HOPDs
  – OC-HOPDs that were billing under OPPS for covered outpatient services prior to November 2, 2015 (that have not impermissibly relocated or changed ownership)
  – OC-HOPD that qualifies under the Mid-Build or Cancer Hospital exception
  – HOPDs on the campus or within 250 yards of the main hospital or a remote location of a multi-campus hospital
  – All services furnished at dedicated emergency departments
Statutory Exceptions from Site-Neutral Payments for Provider-Based Locations

• How does OC-HOPD get excepted/grandfathered?
  - The 2017 OPPS Final Rule grants excepted status to OC-HOPD if the OC-HOPD furnished any covered OPPS services prior to November 2, 2015, and billed under OPPS in accordance with timely filing limits.
What is a Remote Location of a Hospital?

• Remote location of a hospital means:
  – A facility or organization either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider
  – Comprises both the physical facility that is the site of service and the personnel and equipment used to deliver the service
  – Does not include a “satellite facility”

• Remote locations are considered off-campus of the main hospital, but locations “within the distance” (250 yards) of a remote location are excepted under the Final Rule
Relocation of Excepted OC-HOPDs

- CMS Final Rule prevents excepted OC-HPDs from relocating and remaining excepted
- Concern is need to prevent hospitals from moving excepted OC-HOOPDs to larger facilities to add purchased physician practices
- Must remain at the postal address listed in the hospital’s 855 enrollment record
- CMS believes the intent of the Budget Act was to except only OC-HOPDs as they existed prior to November 2, 2015
Final Rule and Relocation of Excepted OC-HOPDs

- Excepted OC-HOPDs can relocate only for natural disasters, seismic building code requirements or significant public health and public safety
- Not for business reasons (e.g., lost lease)
- CMS has issued subregulatory guidance on extraordinary circumstances process; must apply within 30 days of the occurrence
- CMS Regional Offices will approve or deny relocation requests
Hypothetical Relocation

Grandfathered OC-HOPD

Outpatient Radiology Services

Billed OPPS prior to 11/2/15

New Location in 2017

Outpatient Radiology Services

move

Are the outpatient radiology services furnished at the 2017 new location reimbursed OPPS?
Expansion of Services at Excepted OC-HOPD

- Budget Act did not address whether an excepted OC-HOPD can expand the number or type of services furnished and remain excepted

- CMS proposed to except only those items or services furnished at the OC-HOPD as of November 1, 2015 (when Budget Act enacted)
  - Any items or services not in same “Clinical Family” would not be able to be billed by excepted OC-HOPD under OPPS as of January 1, 2017
Expansion of Services at Excepted OC-HOPD

- Proposal would have regulated what services are excepted at an excepted OC-HOPD by creating 19 Clinical Families
- But did not limit the volume of excepted items or services within a Clinical Family that an excepted OC-HOPD can furnish
- CMS did not finalize the proposal limiting expansion of services into new “Clinical Families”
Expansion of Services at Excepted OC-HOPD

- Under the Final Rule, CMS will pay OPPS rates for all services furnished and billed by excepted OC-HOPDs
- CMS remains concerned about growth at excepted OC-HOPDs
- Concern is with hospitals adding purchased physician practices to excepted OC-HOPDs
- CMS sought feedback about how to limit the type and volume of services and is monitoring service line growth using the “PO” modifier
Is diagnostic radiology furnished in OC-HOPD A in 2017 billed OPPS? Does adding PT/OT affect the grandfathered status of OC-HOPD A? Or the OPPS billing of the other services?
Hypothetical Expansion of Services – Adding Space

Existing OC-HOPD
101 Main Street, Suite A

Proposed Addition

- Outpatient radiology services
- Billed OPPS before 11/2/15

Would radiology services in the Proposed Addition be reimbursed OPPS?

Would other new services in the Proposed Addition be reimbursed OPPS?

If the Proposed Addition address is 101 Main Street, Suite A, would services be reimbursed OPPS?

If the Proposed Addition address is 101 Main Street, Suite B, would services be reimbursed OPPS?
21st Century Cures Act

• Mid-Build Protection
  – February 13, 2017, filing deadline certification and attestation

• Cancer Hospitals
  – 60-day deadline for filing attestation
Recent CMS Space Sharing Concerns

- July 11 CMS Letter
- May 5, 2015 AHLA webinar
  - David W. Eddiger CMS comments
  - Said space sharing does not comply with Medicare hospital conditions of participation
- November 2015 Montana Hospital revocation of provider-based status due to space sharing problem involving visiting specialists with time share lease in provider-based space (appealed)
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
Hypothetical Space Sharing

Building A
First Floor

| Physician Office (not provider-based) | OPPS Services (provider-based) |

- Can both physician office services and OPPS services be furnished in the same building?
- Does it matter if they are in same suite? Have the same address?
- Does it matter if they share a waiting room or registration desk?
New Payment Structure for OC-HOPDs

• CMS responded to provider community comments in Final Rule and clarified its proposed payment rules
  – CMS believes MPFS is the fee schedule of choice for billing nonexcepted items and services
  – Allows hospitals to continue to bill on institutional claim forms and physicians to bill on physician claim forms – allowing revenue to appear associated with appropriate cost center
  – Rates for these services will continue to evolve through 2017, 2018 and 2019
New Payment Structure for OC-HOPDs

• For services furnished on or after 1/1/2017, hospitals bill using the UB-04 institutional claim form with the new “PN” modifier
  – The modifier serves as a site of service code to denote these claims as receiving the new MPFS payment rate

• For services furnished on or after 1/1/2017, physicians bill claims on a CMS 1500 form at the facility rate

• These rates are designed to appropriately capture service-provision resource costs
New (and Evolving) Payment Rate in OC-HOPD

- For CY 2017, CMS established a new MPFS rate for “PN” modified institutional claims to reflect the relative resource costs of furnishing MPFS-reimbursed claims in the hospital setting

- New MPFS reimbursement category for CY 2017 is 50% of OPPS rate for same services
  - Based on relative resource information from the old “PO” modifier data and comparison of ASC rates to OPPS rates, but with OPPS-based geographic modifiers
Final Rule: Change of Ownership of OC-HOPDs

- What happens if another hospital or provider only wants to acquire another hospital’s OC-HOPD (not the main hospital)?
  - Lose provider-based status
  - Lose OPPS reimbursement
  - Can get provider-based status back
  - Cannot get OPPS reimbursement back
Final Rule: Change of Ownership of OC-HOPDs

- Must acquire the entire hospital (not just the OC-HOPD) **AND**
- Agree to assignment of the main hospital’s Medicare provider agreement
- If the buyer of the main hospital and OC-HOPD terminates the existing Medicare provider agreement instead of accepting it, OC-HOPD loses excepted status and will not receive OPPS rates
Final Rule: Change of Ownership of OC-HOPDs

- “Provider-based status is defined as the relationship between a facility and a main hospital provider, not an asset that can be transferred from one provider to another.”

- An individual OC-HOPD cannot be transferred from one hospital to another and maintain excepted status
Final Rule: Change of Ownership of OC-HOPDs

- CMS example of how Final Rule applies to hospital combinations:
  - If a hospital owner combines two certified hospitals under one Medicare provider agreement and one CCN, the OC-HOPD loses excepted status unless it was enrolled as a provider-based department of the surviving hospital and billing under OPPS before 11/2/2015
Change of Ownership of OC-HOPDs Examples

- **#1** – Hospital A sells excepted OC-HOPD to Hospital B
- **#2** – As above, but the OC-HOPD is within 250 yards of Hospital B
- **#3** – Hospital A sells excepted OC-HOPD to Hospital B, which has remote location Y. The OC-HOPD is within 250 yards of Y
Change of Ownership of OC-HOPDs Examples

• #4 – Hospital A has two campuses, Main Campus and Remote Location. A sells Remote Location to:
  – Entity not yet enrolled in Medicare
  – Hospital B, which is 24 miles from Remote Location
  – Hospital B, which is 40 miles from Remote Location
Change of Ownership of OC-HOPDs Examples

• #5 – Hospital A has two campuses, Main Campus and Remote Location, as well as three excepted OC-HOPDs, which are within 250 yards of Remote Location. Hospital A sells Remote Location and three excepted OC-HOPDs to Hospital B. Hospital B is more than 250 yards from Remote Location and each of the three excepted OC-HOPDs.
340B Implications

- Hospitals must qualify and be enrolled as covered entities to purchase 340B-priced drugs
- 340B drugs must be administered in covered entity hospital space that is a reimbursable cost center and identified as such on the cost report, i.e., they need to be provider-based
- Both excepted and non-excepted off-campus PBD sites will qualify for 340B
340B Implications

• Under Final Rule payment policy “services provided at nonexcepted off-campus PBDs will continue to be reported on the hospital cost report”
  – They will have charges associated with services furnished at the location
  – Supports the conception of Section 603 as a payment rule not an elimination of provider-based status

• However, CMS says that HRSA has the final say regarding 340B
Auditing Provider Based Compliance

• Auditing of provider based compliance can be a very time intensive project, but also necessary to promote compliance and identify risk areas with the regulations
  – Audit should focus on what you would need to do in a provider based attestation
  – Auditors should have a solid understanding of the regulations, otherwise risk areas could be missed

• Before you start the audit, meet with key leaders and explain the process, needs and risks
  – Be sure leadership understands the importance, as the audit will require significant assistance from a diverse group of people and teams

Disclaimer: this auditing section may not encompass or discuss all required aspects of a provider based attestation; please reference your MAC for the required documents, etc.
Auditing Provider Based Compliance

- Conduct site visits of both on and off campus departments as part of the audit process
  - There are more requirements for off campus locations, thus more to audit
- The CMS Provider Based Attestation document should be your guide in the audit
  - Utilize a checklist to keep track of documents, policies, photos, etc.
  - We submitted hundreds of pieces of paper for 1 off campus provider based attestation

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Where to Start?

• The first step is to identify all of your hospital outpatient departments that are on and off campus. There are variety of sources you can use to determine these departments, for example:
  – Accreditation documents (HFAP, TJC)
  – Cost report data
  – CMS Enrollment documents (855’s)
  – Locations posted on your hospital’s website
  – Data out of your EMR (departments, cost centers, etc.)
Get Organized!

• Utilizing a checklist we created in Excel, we started by conducting the site visits. The site visits focused on the following areas:
  
  – Hear how phones are answered
  – Collect forms, letterhead and other documents that are given to patients
    ◦ Consent form
    ◦ Notice of Co-Insurance
    ◦ Face sheets/discharge instructions
  – Internal/External signage (take photos for your audit documents)
    ◦ Make sure your Marketing team is well versed and understanding of the public awareness requirements—you don’t want the Marketing strategy to put your signage/advertising out of compliance!
    ◦ Signs on interior/exterior doors
    ◦ Suite signs (make sure separate suite numbers)
    ◦ Doors into treatment areas
    ◦ Signage at registration/scheduling areas
    ◦ Facility directories, signs at elevators, etc.
Get Organized!

- Verification that space was not shared in the following areas:
  - Waiting room/lobby
  - Employee break room
  - Staff
  - Restrooms
  - Registration/scheduling areas
  - Equipment/supply closets
## Sample Checklist

### Provider Based Compliance Audit Checklist

<table>
<thead>
<tr>
<th>Documents Required</th>
<th>Provider Based Department Name/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Department/Person Responsible</strong></td>
<td><strong>Date Requested</strong></td>
</tr>
<tr>
<td>Provide your Annual Registration Report</td>
<td></td>
</tr>
<tr>
<td>Provide a copy of the hospital license that lists the provider-based entity's address, or a letter from the State notifying the provider that the entity is included in the hospital's license. Note: If the State does not issue a separate license for the provider-based entity, please provide documentation that the State does not require the entity to be licensed separately (i.e., letter or e-mail from the state indicating a separate license is not issued for provider-based entities or a copy of the State regulation).</td>
<td></td>
</tr>
<tr>
<td>Provide a list of key personnel (i.e. table of organization) working at the provider-based facility showing job titles.</td>
<td></td>
</tr>
<tr>
<td>Provide list of all clinical staff (i.e. physicians, nurses, physical therapists, radiology technicians, etc.) working at the facility or organization showing job titles and name of employer. Also include whether professional staff have clinical privileges at the main provider.</td>
<td></td>
</tr>
<tr>
<td>Provide a written description of the level of monitoring and oversight of the facility by the main provider as compared to oversight for another department of the main provider</td>
<td></td>
</tr>
<tr>
<td>Provide a description of the responsibilities and relationship between the Medical Director of the provider-based facility, the Chief Medical Officer of the main provider, and the Medical Staff Committees at the main provider.</td>
<td></td>
</tr>
<tr>
<td>Provide a written explanation of how inpatient and outpatient services of the facility and the main provider are integrated. Include examples of integration of services, including data on the frequency of referrals from inpatient to outpatient facilities of the provider, or vice versa</td>
<td></td>
</tr>
</tbody>
</table>
Now What?

- Start collecting documentation and check off your master list once you obtain the documentation. For example:
  - CMS 855A: make sure the HOPD location has been added to the CMS enrollment forms under the main provider
  - Location verification: print out a map from MapQuest to prove the distance between the main provider and the HOPD
  - Accreditation documents and/or state licensure
  - Lease documents: who owns the building?
  - Update hospital website: HOPD locations must be held out to the public as a department of the main provider
    - For example: Townville Imaging, a Service of ABC Hospital
Documentation for Audit-On/Off Campus

• Clinical Services Integration
  – Key personnel working at HOPD
  – Organizational charts
  – By-laws or other documents regarding clinical privilege requirements and oversight by medical staff committee at main provider
  – Medical Director agreements
  – Proof that inpatient and outpatients services are integrated

• Financial Integration
  – Cost Report
  – Trial balance showing revenues and expenses of the HOPD in relation to the main provider
Documentation for Off-Campus

• Ownership and Control
  – Documentation to prove HOPD is 100% owned by main provider
  – Proof that HOPD has same governing body
  – Key contracts are the same for HOPD and main provider

• Administration and Supervision
  – Documentation to show the same monitoring, oversight, and supervision by hospital leadership of the HOPD as the main provider
  – Proof that administrative functions are all integrated, i.e. payroll billing, HR, purchasing, etc.
Collection of Required Policies

- Policies must be in place regarding the following topics and employees must be aware of the policy:
  - EMTALA
  - Correct Site of Service (place of service)
  - Non-discrimination provisions
  - 3 day payment window
  - Co-Insurance Notice
  - Unified medical record system
Finalize Audit!

- Complete attestation document as if you are attesting to your MAC
- Keep all required documents together in a central repository in case you are audited by an external agency
- Make all necessary changes promptly!
Additional Audit Check Points

• Make sure PO and PN modifier are being used correctly
• Establish an entity wide process to follow when departments move, new one’s get added, etc. to be sure provider based rules are followed
• Make sure all forms, marketing material, website, signage, etc. is consistent and compliant
Questions?

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