Auditing Hospital Provider-Based Operations

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Presentation Faculty

Duane C. Abbey, Ph.D., CFP – Dr. Abbey is a healthcare consultant and educator with over 20 years of experience. He has worked with hospitals, clinics, physicians in various specialties, home health agencies and other health care providers.

His primary work is with optimizing reimbursement under various Prospective Payment Systems. He also works extensively with various compliance issues and performs chargemaster reviews along with coding and billing audits.

Dr. Abbey is the President of Abbey & Abbey, Consultants, Inc. A wide range of consulting services is provided across the country including charge master reviews, APC compliance reviews, in-service training, physician training, and coding and billing reviews.

Dr. Abbey is the author of eight books on health care, including:

- "***Non-Physician Providers: Guide to Coding, Billing, and Reimbursement***"
- "***Emergency Department: Coding, Billing and Reimbursement***", and
- "***Chargemasters: Strategies to Ensure Accurate Reimbursement and Compliance***".

His most recent book, "**Compliance for Coding, Billing & Reimbursement A Systematic Approach to Developing a Comprehensive Program**" is available from the Productivity Press a Division of Taylor and Francis..

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Auditing Provider-Based Operations
Warm-Up Exercises

- **The Apex Medical Center owns and operates a family practice clinic that is located on its campus right across the street. There is a sky-walk and there is a large parking ramp right next to the clinic. The physicians and all the staff personnel are employees of the hospital. Due to competitive pressures, the only billing made is the professional component on a CMS-1500. Is this a provider-based clinic?**
  - **Yes?**
  - **No?**
  - **Depends?**
- **Is the ED at the Apex Medical Center a provider-based department?**
  - **Yes?**
  - **No?**
  - **Depends?**

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Auditing Provider-Based Status
Warm-Up Exercises

- The Therapy Services Department at the Apex Medical Center wants to establish several clinics within the general area. The clinics will be located up to 10 miles away. A wide range of services will be provided including prosthetics, orthotics and provision of DME. The Compliance Office at AMC has been contacted to see if there are any unusual compliance concerns that should be addressed.
  - Will these PT clinics be provider-based?
  - Are there any provider-based issues?
  - Coding, billing issues?
- A group of oncologists established an infusion center including medical offices about twelve year ago. Chemotherapy services along with blood transfusions and related services are provided. Apex has deferred providing chemotherapy services and blood transfusions. The group of physicians now want Apex to contract with the physicians so that the operation will remain the same, except the hospital will bill for the services and then pay the physicians the contracted amount for services, staff, etc.
  - Exactly how is this going to work?
  - Are there provider-based issues involved in this change?
  - What is the motivation for such an arrangement?

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Auditing Provider-Based Status
Introduction

- Provider-Based Rule (PBR)
  - Difficult Rule To Interpret and Apply Organizationally
  - Almost a Stealth Rule – May Be Overlooked
    - Penalties Involve Only Recoupment of Overpayments
  - Subtle Organizational Issues
  - Correlation to NPIs and CMS-855 Billing Privileges
  - Certain PBR Provisions Need Interpretation
- PBR Reviews and Audits
  - Need to periodically review organizational structuring, coding, billing & associated activities for compliance.
  - Provider-based activities are growing because economic incentive is still very much present.
    - Had Anticipated Provider-Based Clinic Increased Payment Would Be Gone By Now
    - OIG Is Opposed to Payment Differential

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Auditing Provider-Based Operations
Introduction

- What is Provider-Based Status?
- Why Have Provider-Based Status?
  - Variable Reasons – Integration of Services
  - For Clinics → Generate Additional Income
- CMS Interested In Those "Situations" Where There Is A Payment Differential ← Determination
- Note: Provider-Based Status and the Provider-Based Rule Are Medicare Concepts → Other Third-Party Payers May or May Not Recognize!
  - Be Careful With Terminology
    - ✓ Provider-Based *Clinics*
    - ✓ "Facilities" and "Organizations" ← Formally In The PBR
    - ✓ "Operations" and "Situations" → Informal Use In This Workshop
    - ✓ Other PBR Aspects (For Example Prohibitions)

➢ Note: PBR Encompasses More Than Just Outpatient Situations – Also Covers Inpatient Services/Situations

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Auditing Provider-Based Operations
Introduction

➢ Provider-Based Rule – Special Situations

- RHCs and FQHCs Are Special and 42 CFR §413.65 Applies To A Certain Extent (See Also CAHs)
  - Still Referred To As 'Provider-Based'
  - Special Rules
  - Difficulties With APC Interface
- Freestanding Is The Opposite Of Having PBS
  - Freestanding Clinic or Situation Is One In Which There Is No Integration With A Hospital (Main Provider)
  - "Freestanding" Is An Organizational Concept, Not Necessarily a Physical Concept
  - Example – A hospital may own and operate a clinic inside the hospital itself, but the clinic may operate as a "freestanding" clinic by filing only a CMS-1500. ← See Warm-Up Exercise
  - See also, Transmittal 87 to Publication 100-04 → Withdrawn(!)
- OIG Concerns – Provider-Based Clinics
  - Really Don't Want PBS Clinics At All!
  - Should Be No Payment Differential → See Medicare "Site-of-Service" Differential

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Auditing Provider-Based Operations
Introduction

- Provider-Based Supervisory Guidance
  - CMS has made a significant change in their guidance for direct physician supervision relative to provider-based clinics.
    - Note: CMS claims that this is NOT a 'change', only a clarification.
      - ✓ Why would CMS make this claim?
    - See Transmittals 82, 101 and the July 18, 2008 and November 28, 2008 *Federal Register* discussions.
    - Clearly, CMS is now stating that for provider-based clinics that are on-campus, but not inside the hospital, that direct physician supervision is required.
      - ✓ Consider an on-campus infusion center.
    - The way the change has been worded, it is quite possible that this direct physician supervision also applies to in-hospital operations.
    - Previously, for on-campus (and in-hospital) CMS presumed that there would be a physician/practitioner close by.
      - ✓ Note: Read the transmittals carefully. While CMS indicates added language, deleted language is not indicated.

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Auditing Provider-Based Operations
Introduction

- This change or clarification appears to be a technical issue, but this could become a RAC issue with claims of overpayment.
- Consider the Infusion Center referenced in the previous slide.
  - Many hospitals have infusion centers that provide chemotherapy, infusions, injections, blood transfusions and the like. Sometimes these operations are on campus but in a different building or in a building that is attached to the hospital. In these cases the operation is on-campus, but not in the hospital.
  - With CMS's change/clarification, direct physician supervisions is not assumed just because the operation in on the hospital campus or premises. Thus, an infusion center of the type described above would have to have a physician or practitioner in the center immediately available.
  - If this is NOT a change, then this interpretation can be applied retroactively. See MMA Section 912.
  - Thus, a RAC could claim that the infusion center services were provided without proper physician supervision and thus all such payments are invalid and considered overpayments.

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Auditing Provider-Based Operations
Brief History

- **The Provider-Based Rule Is Complex and There Is Confusion**
  - **Several Areas Where The Rules Are Not Clear**
  - **Tortuous Development of PBR – Not separately addressed in *Federal Registers*.**
- **Provider-Based Clinics → 1980's**
  - **Additional Income From Both A UB-04 Technical Component and CMS-1500 Professional Component**
  - **Very Little Reduction in Payment for Professional Component – Site-Of-Service Differential Applied To Only A Few Codes**
  - **Savvy Hospitals Started Using This Organizational Concept → See MAP – Model Ambulatory Practice – Clinics**
- **Mid-1990's – CMS (Then HCFA) Became Concerned About Proliferation of Provider-Based Clinics**
  - **Issued the *Infamous* PM A-96-7 (Re-Issued As PM A-99-24)**
  - **8-Criteria For Being Provider-Based Clinic**
  - **Not Legislated and Not In Code of Federal Regulations**

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Auditing Provider-Based Status
Brief History

- **April 7, 2000 – Issued New Comprehensive Rule**
  - **Note: Yes, this was issued in the APC FR Entry**
  - **The new Provider-Based Rule went beyond just considering outpatient situations. Inpatient situations are also included.**
  - **The new PBR formalized the criteria issued in PM A-96-7 and then some!**
- **Health Care Community Reaction – Congressional Action**
  - **BIPA 2000 – Grandfathering Until October 1, 2002**
- **May 9, 2002 *Federal Register* – Updated Rules – Grandfathering Until 1st Cost Report On/After July 1, 2003**
- **August 1, 2002 *Federal Register* – Further Updates Finalized Except EMTALA Changes**
- **May 14, 2005/August 12, 2005 *Federal Register***
- **To Understand PBR – You Must Master and Understand Multiple References – CFR Sections, Federal Register and Associated Sources**

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Auditing Provider-Based Status
References/Resources

- Main Federal Register Entries
  - April 7, 2000 ← Original APC FR
  - November 13, 2000 ← APC Update FR
  - November 30, 2001 ← APC Partial Update FR
  - May 9, 2002 ← DRG Update FR (!!)
  - August 1, 2002 ← Final DRG Update FR
  - May 14, 2005 ← DRG Update FR
  - August 12, 2005 ← Final DRG Update FR
  - Download Instructions
    - See www.APCNow.com website.
- Program Memorandum – A-99-24 – "Old" Rules
- CMS PBR FAQ + CMS APC Education – MedLearn Chapter 6
- Code Of Federal Regulations
  - 42CFR §489.2 ← Provider Agreement Definitions
  - 42CFR §412.22 ← Inpatient PPS
  - 42CFR §410.27 ← Outpatient Services/Supplies
  - 42CFR §489.24 ← Emergency Requirements
  - 42CFR §413.65 ← Main PBR Rules

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Auditing Provider-Based Status
General Compliance Concerns

- The PBR Is A Strange Rule From CMS
  - When CMS developed this rule over more than ten years, we fully expected significant compliance demands from CMS.
  - During the process CMS realized that they, CMS, would be receiving thousands of requests for determination and/or attestations.
    - Thus, as the final rule evolved, the burden of proof has been shifted from an affirmative process for CMS to a verification process for the providers. Providers must be able to verify that they, the providers, are meeting all the requirements, prohibitions and obligations under this rule.
      - ✓ Voluntary Attestation Process – See PM A-03-030
      - ✓ Requests for Formal Determination – Check with FI and RO
  - Penalties involve recoupment of payment as shown on the next slide.
  - How does this affect auditing processes?

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Auditing Provider-Based Status
General Compliance Concerns

- **From 42 CFR §413.65(l)(2)**
  - **If CMS determines that a facility or organization that had previously been determined to be provider-based under this section no longer qualifies for provider-based status, and if the failure to qualify for provider-based status resulted from a material change in the relationship between the provider and the facility or organization that the provider did not report to CMS under paragraph (c) of this section, CMS will take the actions with respect to notice to the provider, adjustment of payments, and continuation of payment described in paragraphs (j)(3), (j)(4), and (j)(5) of this section, and will recover past payments to the provider to the extent described in paragraph (j)(1)(ii) of this section.**

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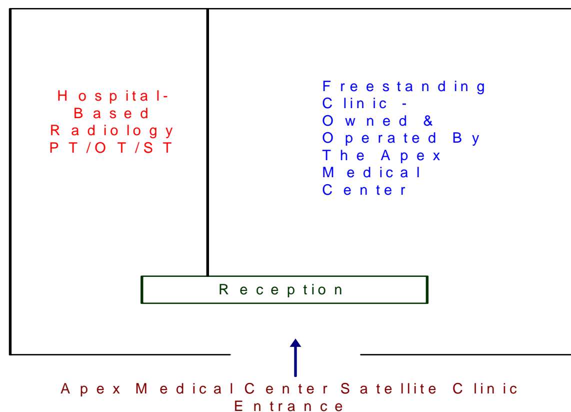
Auditing Provider-Based Status
PBR Exercise # 1

- **Apex Medical Center Satellite Clinic**



The chart shows that Apex has a split use satellite operation. Part is provider-based and part freestanding. Hospital personnel provide all services. Comment to all related Provider-Based Rule concerns and considerations.

Notes:

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Auditing Provider-Based Status
"Old" Rules

- Basically Eight Criteria → See (In)Famous PM A-96-7
  - Geographic Proximity
  - Integral and Subordinate Part
  - Under Accreditation
  - Common Ownership and Control
  - Day-to-Day Supervision
  - Clinical Services Integration
  - Held Out To The Public
  - Financial Integration
- These "old" criteria where brought forward and placed in Section 413.65 of the CFR
- Some Changes → Accreditation to Licensure
- The new rules basically formalized the old rules with much more explicit terminology.
- The new rules also expand the scope of coverage to all hospital situations. For example, prohibition against "under arrangements" can apply to any department.

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Auditing Provider-Based Status
Medicare PT/OT/ST Payment Cap

- Exercise – The Apex Medical Center has aggressively set up a number of PT/OT clinics in the surrounding geographic area. There are seven such clinics two of which are more than 35 miles away. These clinic are organized as provider-based with billing on the UB-04.

  With the recent implementation of the PT/OT cap in payments to freestanding PT/OT operations, Apex is wondering if there is anything they need to do relative to the PBR and their PT/OT clinics.

  - What do you think?

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Auditing Provider-Based Status
Overall Analysis Template

- **Qualifying and Application/Attestation**
  - **This Involves Determination of Provider-Based Status Situations Such As Clinics and Other Activities**
- **Prohibitions**
  - **Prohibitions Can Apply To Any and All Hospital Activities**
- **Obligations**
  - **Obligations Can Apply To Any and All Hospital Activities**
- **Reporting**
  - **Report Any 'Material Changes' ← Relationship to CMS-855 Forms?**
- **These four items must be considered for a wide range of circumstances. Auditors need to carefully consider each of these four issues for their organization.**

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Auditing Provider-Based Status
Definitions

- **Definitions Are The Key**
- **For Auditing Purposes, Differentiate Between:**
  - **In-Hospital**
  - **On-Campus (Out of Hospital)**
  - **Off-Campus (Obviously Out of Hospital)**
- **"*Main provider* means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control."**
- **"*Freestanding Facility* means an entity that furnishes health care services to Medicare beneficiaries and this is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity."**
- **"*Department of a provider* means a facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section."**

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Auditing Provider-Based Status
Definitions

- ***Campus*** **means 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 with 250 yards of the main building, and any other areas determined on an individual case basis by CMS regional offices, to be part of the provider's campus."**
- **"*Provider-based entity* means a provider of health care services, or an RHC or an FQHC as defined in §405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section."**
- **"*Remote location of a hospital* means a facility or an organization that is 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, in accordance with the provisions of this section."**

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Auditing Provider-Based Status
Definitions

- **A *satellite facility* is a part of a hospital that provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital.**
- **"*Provider-based status* means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section."**
- **One of the key and most difficult concepts to understand is that of the "department of a provider".**
  - **The FR language to be put into §413.65 states:**
    A department of a provider:
    - **May not be licensed to provide health care services in its own right;**
    - **May not by itself be qualified to participate in Medicare as a provider under §489.2 of this chapter; and**
    - **Medicare conditions of participation do not apply to a department as an independent entity.**

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Auditing Provider-Based Status
PBR Exercises #2 & #3

- Exercise – The Apex Medical Center has its own Home Health Agency. It is located about five blocks from the hospital. It has its own billing system, its own medical record keeping system and generally operates independently from the hospital. However, there are routine reporting relationships and it is financially integrated with the hospital in that it is on the hospital cost report. Under PBR, what is the HHA's status? Must a PBS determination be made (e.g., file an attestation, etc.)? Discuss.

- Exercise – Two to four days prior to outpatient surgery patients are encountered for their pre-surgery workup. A nurse assesses them, forms are filled out, provides education, the pre-anesthesia questionnaire is filled out and lab, x-ray and EKGs are performed. These services are provided in a dedicated area in a separate building on the campus of the Apex Medical Center. This building also houses various specialty clinics. How should these services be coded and billed? What impact does the Provider-Based Rule have in this type of situation?

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Auditing Provider-Based Status
PBR Exercise #4

- Late in 2007, the Apex Medical Center established a new Pain Management 'Clinic'. These pain management services were provided by MDAs and CRNAs and involved making assessments and providing various injections. This was established as a service in the outpatient services area. Outpatient registration was used and nursing staff from the outpatient services area were used. Hospital bills on a UB-04 and the MDAs bill on a CMS-1500 (with the correct POS).

  Over the time, the pain management services have significantly grown in volume. Now the 'clinic' is located in a dedicated area in the basement of the hospital. There is a separate entrance, dedicated parking, there is separate registration and dedicated nursing staff. There is a separate section on the Chargemaster. Billing remains the same. Also services now include acupuncture, message therapy, PT and behavioral counseling.

  Discuss any and all PBR considerations. Should an attestation be filed for this 'clinic'? Explain why or why not! When did this become a 'clinic'? In the beginning these were really 'provider-based clinical' services. This illustrates how services can come into existence without specific notice.

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Auditing Provider-Based Status
Applicability Issues

- Outpatient versus Inpatient
- In-Hospital vs. On-Campus vs. Off-Campus
- Physician Supervision → §410.27
  - Off-Campus Obligation
  - Now Also → On-Campus Outside of Hospital Itself (Clarification – 2008)
- EMTALA PBR Related Rules → §489.24
- Reporting Requirements
  - Who? When? Where?
- Written Notice of Patient Liability – Off-Campus
  - Notice of Two Co-Payments If Appropriate
  - Specific versus Language with Examples
- Pre-Admission Window Requirements – Owned or Operated – Not Necessarily Required To Be PBS Clinics
  - Certainly applies to provider-based clinics, but 'ownership or control' will trigger the DRG pre-admission window.

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Auditing Provider-Based Status
Qualifying For PBS

- Need To Audit For Each Criteria – Not A Preponderance of Requirements
- Licensure
  - Licensure Is A State Level Process
  - Licensure versus Accreditation
- Operation Under Ownership and Control of Main Provider
  - 100% Ownership
  - Same Governing Body
  - Same Organizational Documents
  - Main Provider – Final Administrative Responsibility
- Administration and Supervision
  - Direct Supervision
  - Same Monitoring and Oversight
  - Administrative Integration

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Auditing Provider-Based Status
Qualifying For PBS

- Clinical Services
  - Professional Staff – Same Privileges
  - Common Monitoring
  - Medical Director
  - Medical Staff Organization
  - Medical Records – Integrated (Cross Referenced)
  - Inpatient and Outpatient Services Integrated
- Financial Integration
- Public Awareness
- Location In Immediate Vicinity
  - 75%-75% Rule
  - 75% Rule
  - Special Situations
  - BIPA → 35 Miles
    - Question: Where else do you see this 35-mile limitation?

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Auditing Provider-Based Status
PBR Exercise #5

- About five years ago, the Apex Medical Center acquired (merged) the other hospital in Anywhere, USA. There are now two campuses about 17 miles apart. No inpatient services are provided at the other campus which is referred to as the Summit Campus since that was the name of the other hospital.

  The Summit Campus is quite active an provides a wide range of outpatient services including outpatient surgery, ED, observation, clinical services, psychotherapy services, etc. Additionally, Summit continues to have a very active PT/OT/ST service area which has 10 different PT/OT clinics up to 25 miles away from the Summit Campus. There are also several family practice clinics still being operated that were owned by Summit.

  Comment to any concerns and/or opportunities that might exist under the Provider-Based Rule.

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Auditing Provider-Based Status
Applying For PBS

- Process For Applying
  - Dual Filing - Regional Office Gives Approval
  - Attestation Format + Documentation → PM A-03-030 ← Suggested Format – Variability Allowed
- Attestation Process → See May 9th + August 1st FR (2002)
  - For On-Campus Including In-Hospital (?)
    - Need Only Provide Attestation That Meet All Requirements
    - Documentation Should Be Developed and Available
    - The Explicit Form Of Attestation
    - Blanket Attestation For In-Hospital Activities?
  - For Off-Campus
    - Provide Attestation
    - Provide Documentation → See Application Form
  - Does Attestation Totally Replace Ability To Apply For and Obtain Formal Recognition?

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Auditing Provider-Based Status
Reporting Requirements Under PBS

- The reporting requirements under the new PBS rules and regulations are probably one of the biggest 'sleepers' within these rules. It appears that these rules are already in effect.
  - "A main provider that has had one or more facilities or organizations considered provider-based also must report to HCFA [now CMS] any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership or the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization."
- It is difficult to gauge just how broadly or narrowly this reporting requirement will be interpreted. See comments in November 30, 2001 FR.
- Exercise: The Apex Medical Center has decided to change ED physician services. A new contract has been established and a new set of ER Physicians will be providing services. Does the Provider-Based Rule, relative to the reporting requirement, come into play?

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Auditing Provider-Based Status
Concerns & Prohibitions For PBS

- **Provider-based status not applicable to *joint ventures*. A facility or organization cannot be considered provider-based if the entity is owned by two or more providers engaged in a joint venture. For example, where a hospital has jointly purchased or jointly created free-standing facilities under joint venture arrangements, neither party to the joint venture arrangement can claim the free-standing facility as a provider-based entity.**

  May 9th + August 1st FR (2002) proposes that this would apply only to off-campus situation. On-campus situations OK?

  See May 14th + August 12th FR (2005) for additional clarifying language.

- **Furnishing all services *under arrangement*. A facility or organization may not qualify for provider-based status if all patient care services furnished at the facility are furnished under arrangement.**

  May 9th + August 1st FR (2002) make no change to this prohibition.

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Auditing Provider-Based Status
PBR Exercise #6

- **The Apex Medical Center has contracted with an outside company to provide Hyperbaric Oxygen (HBO) services. AMC is providing space in a building several blocks from the hospital. The outside company is providing the equipment, supplies, a physician, nursing and technical staff. Apex is providing clerical staff for registration, billing, etc. Apex pays the outside company for the services, and then Apex files claims with third-party payers including Medicare.**

  How does the Provider-Base Rule come into play in this situation?

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Auditing Provider-Based Status
Concerns & Prohibitions For PBS

- ***Management contracts***
  - May 9th + August 1st FR (2002) exempts on-campus situation from this prohibition.
  - The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at part 414 of chapter IV of Title 42. Other than staff that may be paid under such a Medicare fee schedule, the main provider may not utilize the services of "leased" employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.
  - Question: How, exactly, does the Management Contract prohibition fit with the Under Arrangements prohibition?

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Auditing Provider-Based Status
Provider-Based Clinics

- **Billing For Freestanding Medical Clinics**
  - Use only the CMS-1500 claim form. Payment is strictly through the RBRVS system. From a hospital perspective, this is just the same as a physician owned, freestanding clinic.
  - Note: POS coding → Clinic
- **Billing For Provider-Based Medical Clinics**
  - Use the CMS-1500 for the professional component.
  - Use UB-04 for the technical component.
  - Note: POS coding on the CMS-1500 → Hospital Outpatient
- **Medicare's Site-Of-Service Differential**
  - See November 19, 2008, *Federal Register* for details.
  - The site-of-service differential or reduction is undergoing changes as CMS works on the RBRVS practice expense component of the RVUs.

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Auditing Provider-Based StatusProvider-Based Clinics

- Economic Advantage For Being PBS Medical Clinic
  - See chart on next page for a simple example.
  - Note that this takes into account ONLY the financial aspect of a much larger issue, namely the overall cost-benefit for being a PBS medical clinic.
- Split-Billing Required Only For Medicare
  - See April 7, 2000 FR
  - What if Medicare is secondary?
- Co-location Questions
- Cost Reporting Concerns
- Incorrect Classification – Recoupment Of Payments?

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Auditing Provider-Based Status
Provider-Based Clinics-Operational Issues

- Management Structure – Preparation of organizational charts showing the integration of the management of the provider-based clinics into the hospital organization.
- Medical Staff Organization – Medical Staff Bylaws – Consideration for any separate organizational structures and/or changes to Medical Staff Bylaws
- Conditions of Participation – Review for any changes that must be made at the clinics in order to meet hospital Conditions of Participation.
- Medical Record Keeping System – Changes in order to integrate the medical/patient record keeping systems and/or appropriately cross-reference at each location.
- Geographic Location – Special considerations for any cases where the provider-based clinics are more than 35 miles from the hospital.
- Campus Determination – Contiguous location that is more than 250 yards from hospital – special determination by Regional Office.

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Auditing Provider-Based Status
Provider-Based Clinics-Operational Issues

- Billing System – Common management and/or physical integration. This also involves decisions about how the CMS-1500s and UB-04s will be generated.
- Claims Filing – Decisions about which third party payers to split-bill:
  - Medicare Primary Only
  - Medicare Primary and Secondary
  - Third Party Payers Recognizing Provider-Based Status
  - Third Party Payers Not Recognizing Provider-Based Status
- Claims Filing – Making certain that the correct POS (Place of Service) is on the CMS-1500.
- Claims Tracking – Adjustments to computer billing system(s) to properly track adjudicated claims.
- Charge Structuring – Establishment of fee schedule for professional and technical component that is consistent with the global professional fee structure and also compliant with the Medicare Charge Rule.

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Auditing Provider-Based Status
Provider-Based Clinics-Operational Issues

- Patient Recognition – Signage, letterhead, encounter forms, etc. should all be for the hospital. Changes may be necessary.
- Human Resources – Integration of employee pay scale, fringe benefits and retirement benefits.
- Off-Campus Provider-Based Clinic Requirements:
  - Physician Supervision
  - EMTALA Representative and Protocols
  - Notice to Patients of Two Co-Pays
- Education/Training – Patients and provider-based clinic staff will need to be trained and/or acclimated to new processes.
- CMS Questionnaire – Filling out the questionnaire, providing additional information and gaining approval for provider-based status.
- Compliance – Documenting the overall process and establishing documentation for sensitive areas (e.g., why separate TINs are being used).
- Coding – Technical component E/M coding selection process. Determination of the mechanism and who does the coding.
- Compliance – Assurance that technical component and professional component coding (surgical, medical procedures and diagnoses) correspond.

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Auditing Provider-Based Status
PBR Exercise #7

- The Acme Medical Clinic is a freestanding physician-owned clinic across the street and down the road about 3 blocks from the Apex Medical Center. There are five family practice physicians, two internal medicine physicians and three surgeons at the clinic.

  The physicians and the hospital have been talking for a number of years about having Apex 'buy' the clinic. The Apex Medical Center's Board has finally approved the acquisition.

  You have been selected to head up the team that will finalize the acquisition and make all of the necessary changes. Of course, administration has decided to make this a Provider-Based Clinic since increased reimbursement is available.

  Outline your concerns and necessary action steps in order to acquire and integrate the Acme Medical Clinic into the Apex Medical Center (as a main provider).

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Auditing Provider-Based Status
PBR Exercise #8

- Exercise – The Apex Medical Center is in the process of trying to determine whether or not to convert several freestanding clinics (owned by the hospital) into full-fledged provider-based clinics. Apex has 15% regular Medicare patients (traditional) and an amazing 35% Medicare Advantage patients. The Medicare Advantage program is a fee-for-service program paying the physicians 115% of their normal Medicare payment. Only the physicians have a contract as such, the hospital is paid through the regular APC process.

  - Question: Will there be an economic gain by being provider-based under the Medicare Advantage program?
  - Assume that Apex will gain $750,000.00 per year from the traditional Medicare program. How much could potentially be gained from the Medicare Advantage program?

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Auditing Provider-Based Status
Reviewing PBR Requirements

- **Four-Prong Considerations**
  - Need For Determination/Attestation
  - Prohibitions
  - Obligations
  - Reporting
- **Identification of All "Potential"**
  - Facilities
  - Organizations
  - Activities
  - Operations
- **See Flow Chart**

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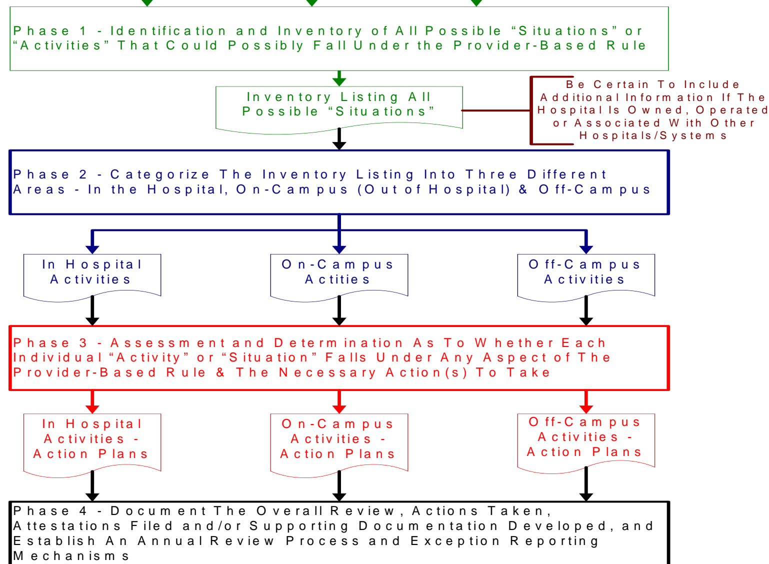
Basic Flow Chart For Provider-Based Rule Analysis

Hospital Information - Organizational Information - Service Areas - Licensing
Accreditation - Chart of Accounts - Campus Map - Clinic Inventory



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Developed By Duane C. Abbey, Ph.D., CFP
See Associated Detailed Instructions & Interpretations

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Auditing Provider-Based Status
Reviewing PBR Requirements

- Phase 1 – Inventory
  - Identify Everything! More is better! You can always exclude at a later phase.
  - Look for unusual situations. Check licensing, accreditation, certifications, organizational charts, Medical Staff Bylaws, accounting information, management contracts, campus map, and the like.
- Phase 2 – Categorize
  - In-Hospital vs. On-Campus vs. Off-Campus
  - May Not Be As Easy As Anticipated!
- Phase 3 – Assess
  - Use the Four-Prong Approach To See If Any of the “Situations” Come Under Any Aspect of PBR
- Phase 4 – Develop Action Plans
  - Attestation/Documentation Development
  - Reorganization Relative To Prohibitions
  - Organizational Change To Meet Requirements
  - Check for Obligation Compliance

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Auditing Provider-Based Status
Application/Attestation Process

- See PM A-03-030 + Previous Questionnaire → Some Documentation Requirements Are Listed As A Part of the Attestation Checklist
- Question: Do you have to obtain approval before billing for a ‘new’ or ‘changed’ provider-based situation?
- Question: What is the process? FI or RO??
- In-Hospital
  - Blanket Attestation For “Routine” Situations + Retained Documentation Development
  - Individual Attestations For “Unusual” Situations
- On-Campus
  - Individual Attestations For Most Situations
  - Develop Documentation and Retain
- Off-Campus
  - Attestations Plus Submitted Documentation
  - Note Special Obligations

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Auditing Provider-Based Status Application/Attestation Process

- **Documentation Development (May Vary Depending Upon Specific Activity or Operation)**
  - Copies of Licenses
  - Accreditation/Certification Information → Listing of Surveyed Entities
  - Medical Staff Bylaws For Subordinate Activity
  - Organizational Charts
  - Job Descriptions → Management, Financial, Clinical (for example, Medical Directorships)
  - Contracts – External/Management
  - Clinical Forms
  - Business Forms – Charge Sheets, Documentation Forms
  - Signage, Advertising, Brochures for Public Awareness
  - Phone Directory Entries
  - Mailing Address Considerations

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Auditing Provider-Based Status Application/Attestation Process

- **Documentation Development - Continued**
  - Financial Organization – Chart of Accounts
  - Map of the Campus and Off-Campus Situations
  - Credentialing Processes Relative To PBS Situations
  - Off-Campus
    - Emergency Policies
    - Samples of Two Co-Payment Notices
    - Medical Staff Bylaw – Physician Supervision
  - Other Pertinent Information
- See PM A-03-030 For Further Information
- How does this fit into the CMS-855 process?

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Auditing Provider-Based Status
PBR Case Studies

- **Mobile Services – CAT Scan, MRA, Clinic**

  The Apex Medical Center is in the process of purchasing their own CAT Scanner. In the meantime a mobile unit comes twice a week.

  a. The hospital leases space to the outside entity. The outside entity provides all the services and provides their own billing.

  b. The hospital contracts with the outside entity. The entity provides all the services including personnel. The hospital pays the outside entity under the contract and then bills for the services on a UB-04.

  Comment to these two cases relative to PBR.

What if a main provider is sending out a mobile clinic to a remote location with a Nurse Practitioner. Both a technical component and professional component are billed by the hospital. The location is a parking lot at a local discount store.

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Auditing Provider-Based Status
PBR Case Studies

- **Apex Medical Center – Specialty Clinics**

  The Apex Medical Center hosts a number of specialty clinics. The specialists come to the hospital two to three times a month and hold a clinic for a day or two in some cases. There are two different approaches taken for the relationship with the physicians:

  1. There is a rental charge to the physician (only the physician bills and files a claim form), or

  2. There is no rent. Both the hospital and the physician bill and file claim forms (independent of one another).

  Comment to provider-based status concerns in both of these cases.

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Auditing Provider-Based Status
PBR Case Studies

- **Coding/Billing For Provider-Based Clinics**

  The Apex Medical Center has acquired the Acme Medical Clinic and has decided to organize it as a provider-based clinic. The application has been made to the CMS Regional Office and written confirmation has been received.

  It has also been decided to split-bill Medicare only. This means that a UB-04 and CMS-1500 will be issued only for Medicare patients. All other patients will receive only a CMS-1500.

  A question has arisen relative to Medicare being secondary. If the first payer is, say, a BC/BS program, then only a 1500 is issued. After the first payer makes it payment, it is then necessary to issue to claims to Medicare. But what should the place of service be? How are the proper co-pays calculated?

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Auditing Provider-Based Status
Final Exercise

- **Discuss the Provider-Based Rule relative to:**
  - The various CMS Form 855s.
    - CMS 855-A
    - CMS 855-B
    - CMS 855-I
    - CMS 855-R
    - CMS 855-S
  - Organizational Structuring
    - Official Legal Structuring
    - Business Subunits
    - Tax Identification Numbers
    - National Provider Identifiers (NPIs)
  - Be certain to include a discussion of the various 'reporting' requirements that are found under these Medicare requirements.

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Auditing Provider-Based Status
Summary and Conclusions

- The Provider-Based Rule Is A Complex Rule!
- There Continue To Be Ambiguities Within The Application Of The Rule
- Auditors Must
  - Understand the Provider-Based Rule
  - Make a Careful Organizational Assessment
- Understand the Importance of:
  - Provider-Based Clinics
  - Provider-Based Clinical Services
- PBR Applies To Both Inpatient and Outpatient Services
- Due Consideration Must Be Given To
  - In-Hospital Activities
  - On-Campus Activities
  - Off-Campus Activities
- PBR Is Intertwined with EMTALA and the Inpatient Pre-Admission Window
- Care Must Be Taken to Develop Appropriate Attestations and Associated Documentation

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Auditing Provider-Based Status
Resources For Further Information

For All The Other Multitudinous Documents See:

- Abbey & Abbey, Consultants, Inc. – APC Website
- PBR Information Toolkit

http://www.APCNow.com/PBRInformationToolkit.htm

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