Advanced Issues in Provider-Based Status and Under Arrangements Coverage

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Agenda

• Overview of Authorities
• Provider-Based Status: Advantages and Disadvantages
• Applicability
• Provider-Based Attestations
• Location Issues
• Clinical Integration
• Financial Integration and Billing
• Public Awareness and Shared Space
• Administrative Integration and Personnel
• Under Arrangements Coverage
Overview of Authorities

- 42 C.F.R. § 413.65


- Program Memorandum A-03-030 (April 18, 2003)
Provider-Based Status: Advantages and Disadvantages

• **Advantages**
  – Increased payment amounts from Medicare (and typically Medicaid)
    • Hospital technical charge + Physician professional fee
  – Eligibility for 340B Drug Discount Program
  – Inclusion in main provider payor contracts

• **Disadvantages**
  – Increased coinsurance for beneficiaries
  – Additional compliance expenses
  – CoP violations at remote campus may extend to entire provider
Applicability of Provider-Based Status

• Applies to hospital outpatient departments and remote campuses of main provider

• **Does not** apply when there is no difference in payment (fee schedule or separate PPS)
  
  – For example: ASCs, CORFs, HHAs, SNFs, Hospice, IDTFs, ESRD facilities, clinical laboratories, physical/occupational therapy clinics

• May be applicable for payor contracts
Provider-Based Attestation Process

• Program Memorandum A-03-030
• Approval of an attestation is not required for provider-based billing
• **Advantage**: Peace of mind; internal discipline; if change in status, no overpayment for prior periods up to change
• **Disadvantage**: Onerous; Backlog in MAC approval process
Location Issues

• Provider-based department must be within 35 miles of the hospital’s main campus.

• What constitutes the “main campus”? 
Location Issues

• Difference in requirements between on-campus and off-campus departments

• On campus = Within 250 yards
• Off campus = Within 35 miles

• Distance measured “as the crow flies”

• What constitutes the “main campus”? 
Location Issues

• Main Campus: “Physical area immediately adjacent to provider’s main buildings”

• What is a main building? No CMS definition.

• Is a “main building” by definition exempt from the provider-based requirements?

• Logical interpretation: houses inpatient beds or significant outpatient services

• Urban v. Rural – St. Vincent’s case in New York City
Location Issues

• Can a provider have more than one main campus?
  – CMS says “no” in comments to provider-based regulation
  – Later, CMS says “yes” in comments to physician supervision rules

• If so, may an “on campus” provider-based department be within 250 yards of the remote campus? Within 35 miles for off-campus?
  – Must pass the “optics” test
Location Issues

• **Mobile Units**

  – CMS personnel have confirmed that a mobile unit may be considered provider-based if it meets all requirements of the regulation and operates within a 35-miles radius of main provider.
Clinical Integration

• **Clinical v. Admitting Privileges**
  – The regulation requires only that physicians have “clinical privileges” at the main provider
  – Not necessary that physicians have admitting privileges
  – However, patients seen at provider-based departments must have access to inpatient care at the main provider, if necessary

• How must reporting relationships work?
Financial Integration

• Is use of separate chargemasters acceptable?
  – Can use separate chargemasters for provider-based locations and main provider
  – Must be sure to “gross up” charges on cost report for the same service

• May a provider charge Medicare and commercial patients different amounts?
  – Provider-based department must be held out to payors as part of the main provider
  – Providers must bill commercial payors according to their rules
    • Many commercial payors do not pay hospital technical fees at provider-based clinics
Financial Integration

• Must a hospital own the provider-based department?
  – For off-campus provider-based sites, the hospital must own the “business enterprise”
  – Business enterprise is not expressly defined, except that it is not simply the bricks and mortar
  – Likely satisfied if hospital is booking department’s income and expenses as required by regulation
Public Awareness

• Provider-based department held out to public and payors as part of the main hospital
• Patients must know they are entering a hospital department
  – Intent is to avoid beneficiary confusion when billed for both physician and hospital coinsurance
• Association with a health network or system is not sufficient
Public Awareness

• Inherently subjective standard
• Safest course: “ABC Clinic, a department of XYZ Hospital”
• CMS will evaluate many forms of advertisements/notices
  – Signage, promotional materials, patient notices, HIPAA authorizations, registration forms, websites
• Based on totality of circumstances
  – Likely more flexibility for monument signage than for website
Public Awareness

• **Shared Space**
  – Regulation does not prohibit sharing of space between provider-based department and freestanding entities
    • CMS expressly stated in comments that it would evaluate shared space on a case-by-case basis
  – However, CMS Central and Regional Offices interpret regulation to prohibit sharing of clinical space
Public Awareness

• **Shared Space**
  – Time Blocks
    • CMS position is clear that a provider-based department must be hospital space 100 percent of the time
  – Spatial Concerns
    • Some CMS Regional Offices require separate suite numbers, entrances/exits, registration areas, hallways
    • More common approach is to prohibit sharing of clinical space, but to permit sharing of “common areas,” e.g., bathrooms, waiting rooms
    • Important that hospital patients not pass through clinical space of freestanding entity, and vice-versa
Public Awareness

• **Notices of Coinsurance**
  – Required at off-campus locations
    • Likely also should be used for sites that are on-campus or remote campus
  – Must be delivered **prior** to furnishing service
  – Must include amount of beneficiary’s potential liability
    • If not known, may provide an estimate based on type of services
  – Must be updated annually
Administrative Integration

• Required for off-campus sites

• Must have reporting relationships with same “frequency, intensity and level of accountability”

• May contract out some administrative services but under hospital control and supervision

• Must document oversight – staff/committee meeting minutes show that personnel from provider-based department are present

• Regular walk-throughs of provider-based departments
Personnel Issues

• Must personnel be employed by the hospital?
  – On-campus: No
  – Off-campus: Yes, if there is a management contract
    • Clinical personnel: nurses, medical assistants, technicians
    • Management contract should be held in name of provider, not parent organization

• Presumably, not required if off-campus but no management contract

• Still must meet administrative integration requirements and demonstrate actual control and supervision
Under Arrangements Coverage

• Provider-based regulation prohibits “all” services in a provider-based department from being furnished under arrangements.

• However, a hospital may bill in its own name for hospital diagnostic services furnished by a third-party vendor without the site qualifying as provider-based.

• Therapeutic services must be furnished in a hospital or provider-based department.
Under Arrangements Coverage

• Hospital cannot serve merely as a billing mechanism

• Hospital must exercise professional responsibility over arranged-for services
  – CoP requires hospital Board to oversee contracted services
QUESTIONS?