Provider-Based Billing . . .
It Really Is Rocket Science!

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Xtend Healthcare Advanced Revenue Solutions

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Those Pesky Acronyms

- APC — Ambulatory Payment Classification
- ASC — Ambulatory Surgery Center
- CAH — Critical Access Hospital
- CMHC — Certified Mental Health Center
- CMS — Center for Medicare and Medicaid Services
- CORF — Certified Outpatient Rehabilitation Facility
- DME — Durable Medical Equipment (Supplier)
- ESRD — End Stage Renal Disease
- FQHC — Federally Qualified Health Center
- HHA — Home Health Agency
- IDTF — Independent Diagnostic Treatment Facility
- OPPS — Outpatient Prospective Payment System
- PB — Provider Based or PBC = Provider-Based Clinic
- RHC — Rural Health Clinic
- SNF — Skilled Nursing Facility

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Today's Agenda

- Why is provider-based status so popular?
- Address new audit and OIG emphasis!
- Identified provider-based operation / billing errors
- What does provider-based mean? Legally / realistically
- Review CMS provider-based definitions
- CMS guidance on "how-to" become provider-based
- Provider-based obligations – the good and the bad
- New in 2012, 3-day Payment Window inclusions
- Provider-based Attestation – why so much confusion?
- Provider-based payment review – does it ALWAYS mean increased cash?
- Ensure compliance with ALL requirements!

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Why so many questions about provider-based … ?

- Independent physicians are migrating to hospital employment at a rapid pace.
- Many hospitals prefer provider-based status for physician practice "type" services.
  - Reimbursement is often, but not always, higher!
  - Hospital outpatient services paid at higher rate than MPFS.
  - Hospital able to include P-B cost on Medicare cost report.
- CMS is concerned that a significant number of hospitals fall short of the government-mandated requirements for provider-based status.
- The Office of Inspector General (OIG) lists provider-based "non-compliance" as one of its top concerns.
- The current administration is actively expanding the use of payment recapture audits in federal programs.

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What are some of the identified errors?

- **The Joint Commission surveyed a midwest hospital operating a provider-based clinic.**
  - **During its evaluation, the accrediting organization determined there was a lack of medical-record integration between the hospital and its provider-based clinic.**
  - **As a result, the commission cited the hospital for deficiencies**
  - **Required resolution through a corrective action plan.**
- **Place of Service (POS) *coding "errors"* that may have gone undetected when there was a different FI processing Part A claims than Part B, but claims will be easily discovered now that a single MAC is processing both facility and prof. claims.**
- **If the hospital operates a physician clinic as a provider-based clinic, and Medicare determines it does not meet criteria, *there will be fines and repayments due!***

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Provider-Based Services – The Basics

- Regulation 42 C.F.R. 413.65 defines what operations are part of a Medicare certified provider (vs. supplier such as DME.)
- This regulation determines **what hospital services can be billed under the Medicare provider number.**
- Provider = Hospital, CAH, SNF, HHA, Hospice, CORFs, RHC, FQHC, CMHC
  - Just to confuse ourselves, sometimes we refer to physicians and/or clinicians and therapists as "providers"!
- CMS defines "provider" as the hospital. A provider-based location or site means "hospital-based."
- In other words, **a provider-based location is essentially a department of the hospital providing outpatient services.**
- Be careful with the word "clinic." Also various interpretations!

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Provider-Based - Exclusions

- 413.65 Regulation not applicable to PB status of:
  - ASCs, CORFs, HHAs, SNFs, Hospices
  - Inpatient Rehab Units
  - IDTF's and Labs paid only on fee schedule
  - PT/OT/ST – Unless at a CAH
  - ESRD - see 413.174
  - Ambulance
  - Non-revenue producing departments
- With exclusions, 413.65 effectively only applies to Hospital Outpatient Departments and RHCs
- Remember – a provider-based "entity" has a separate, different provider number.
- A provider-based location (site, clinic) has the same provider number!

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Provider-Based – CMS Definitions

- Main provider – Provider (Hospital) that creates or acquires another location to deliver additional services in its name, etc.
- Campus - physical area of main buildings within 250 yards
- Department of a provider – facility or organization that is created or acquired by main provider to provide services in its name, etc.
  - Must be identified through signage and/or communication efforts as owned by main provider
  - marketing materials, registration, phone listings, websites…….
- Provider-based entity – separately certified provider owned by main provider (traditional "hospital based" concept) SNF, RHC
- Remote location of a hospital – another site that furnishes Inpatient services
- Free-standing facility – entity that is not provider based

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More Provided-Based CMS Definitions

- **<u>Campus:</u>** **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, and any other areas determined on an individual case basis, by the CMS Regional Office, to be part of the provider's campus.**
- **<u>Department of a Provider:</u>** **A facility or organization or *a physician office* that is either created by, or acquired by, a main provider for the purpose of furnishing healthcare 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.**
  - **The department is not licensed to provide health care services in its own right and is not by itself qualified to participate in Medicare as a provider.**
  - **Medicare conditions of participation do not apply to a department as an independent entity.**

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More Provider-Based CMS Definitions

- **<u>Free-standing facility:</u>** **An entity that furnishes healthcare services to Medicare beneficiaries and is not integrated with any other entity as a main provider, is not a department of a provider, a remote location of a hospital, satellite facility, or a provider-based entity.**
- **<u>Main Provider:</u>** **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.**
- **<u>Provider-based entity:</u>** **A provider of healthcare services that is either created by, or acquired by, a main Provider for the purpose of furnishing healthcare services *of a different type* from those of the main provider under the name, ownership, and administrative and financial control of the main Provider.**

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Provider Based – CMS Requirements

- **Universal Provider-Based Department = all facilities or organizations:**
  - **Common licensure for both – If allowed by state law**
  - **Financial integration –**
    - **Must be included in hospital trial balance, and**
    - **Must be included in the allowable cost centers on Medicare cost report, same as any other hospital department**
  - **Clinical integration –**
    - **Same clinical oversight as any hospital department – Medical Director, QA, UR, etc.**
    - **Medical records – unified retrieval system or system that is able to be cross- referenced – that makes charts readily available at all locations**
    - **Medical staff of hospital have clinical privileges at site / facility**

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Provider Based – Legal Requirements

- **OFF CAMPUS SITES:**
- **Required Management Contract terms –**
  - **Provider's control is clear (written P&Ps the same)**
  - **Provider must employ all non-management staff members who provide patient care (excluding those that can separately bill – physicians / mid-levels)**
  - **Management / leadership employees must follow provider policies**
  - **Manager's policies must be approved by provider**
  - **Periodic written reports required to provider**
  - **On-site staff members subject to provider's approval**

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Provider Based – Legal Requirements

- OFF CAMPUS provider-based sites must also meet:
  - Common ownership - same legal entity and governing body
  - Administration and supervision -
    - same supervision as any other provider-based department
    - HR, billing, payroll, benefits, records, purchasing, salary structure done by same employees
  - Location - within 35 miles of main provider or meet market share test
- Management contract rules apply
- Joint ventures prohibited

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What is a Provider-Based Clinic (PBC)?

Here are some of the requirements for a PBC:

- Provider-Based Clinic may be on the hospital's main campus or within 35 miles of the main campus
- Must operate under the Main Provider's (Hospital's) license unless state law mandates separate licensure.
- PBC has ready access to the hospital's and other provider-based clinics' medical records.
- Physicians and staff operating within the clinic are under the same reporting structure as all other hospital departments.
- PBC is incorporated into the hospital's organizational chart.

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What is a provider-based clinic (PBC)?

Additional Requirements for a PBC:

- Directors and managers are involved in the same meetings as their peers in other hospital departments.
- Professional staff must have hospital privileges.
- Support staff receives the same in-service training as the clinical-support staff of the hospital as applicable.
- Hospital policies on infection control, safety, disaster plans, etc., apply at Provider-Based Clinic.
- Signage, name badges, business cards, letterhead, logos, billing invoices, voicemail, etc. are identified as that of the hospital.
- Provider-Based Clinic appears on the hospital's trial balance as an identifiable cost center.
- Must use the same Charge Description Master (CDM) as the hospital.
- Medicare patients must be registered as hospital patients.

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Provider Based – Hospital Department Obligations

Provider (Hospital) has clear responsibility for ensuring:

- **Place-of-service** (POS) indicator for the professional component must be billed at facility RVUs.
  - Not "11" – Office-based physician service
  - Must be "22" – Hospital On-Campus outpatient service
  - Must be "19" – Hospital Off-Campus outpatient service
- All terms of the Medicare provider agreement (Conditions of Participation) are carried out – **deficiencies at any site jeopardize entire hospital provider status.**
- Non-discrimination provisions applicable to physicians.
- EMTALA obligations
  - On campus – apply as part of hospital
  - Off campus – apply if held out as Urgent Care or > 1/3 patient visits are unscheduled

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What is a provider-based clinic (PBC)?

New 2016 Requirements for Off-Campus Dept.'s:

- Implemented new coding and billing guidance for new Modifier for facility claims (other than RHCs), and
- A new POS code for professional claims.
- "PO" Modifier – Appended to every HCPCS code on facility claim.
- New POS code 19 for professional claims.
  - Off-Campus Outpatient Hospital
- Continue to use POS code 22 for On-Campus OP Hospital.

2017

- Only "excepted" Off-Campus PBDs will continue to be paid under OPPS.
- "Excepted" = Operating and billing as Off-Campus PBD before 11/02/15!
- Can include as excepted those "under development" but not billing, and those who had submitted a voluntary P-B attestation before 12/02/15. Grandfathered in.
- Also – "mid-build" attestations allowed during first quarter of 2017.

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Provider Based - Hospital Department Obligations

- Treat all Medicare patients as hospital patients with the **facility / technical component of service billed on UB-04!**
- Inpatients of hospital – **3 day Payment Window applies** to all facility components for services in provider-based entity, AND all diagnostic and related therapeutic professional components!
- **Off-campus sites must provide notice of dual co-insurance** (facility / technical and professional components) to each Medicare patient before services provided (unless emergent service)
- Meet all applicable Medicare hospital conditions of participation
  - includes hospital building code!

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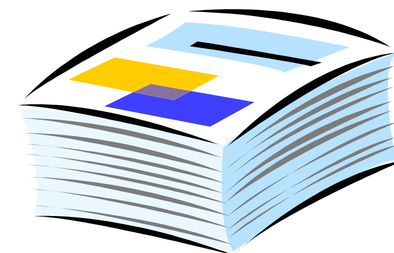
Ensure Claims are Compliant!

To re-state the obvious!

- **The same CPT-4 codes are used to bill physician services provided in an independent (free-standing) physician office or in a provider-based clinic.**
- **CMS pays a greater dollar amount in an independent physician office, but less for the physician component in a provider-based clinic.**
- ***BUT*, CMS is also paying a separate dollar amount for the related APC (facility component) on the UB-04.**
- **CMS is understandably concerned that it does not pay for the APC on the hospital UB-04 claim, and then also pay the non-facility rate for the CPT-4 on the CMS 1500.**



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Ensure Claims are Compliant!

To re-state the obvious!

- In many organizations, billers are either knowledgeable about Part B (physician) or Part A (hospital) claim submission requirements, but they seldom know both.
- Part B billers are accustomed to identifying correct service provision on a claim by using modifiers (TC or 26).
- But split-billing a physician office visit for a provider-based clinic is not really similar to billing a procedure or diagnostic service with modifiers.
- There are no modifiers equivalent to -26 (professional component) and TC (technical component) that would allow a provider to indicate to CMS whether it is billing "globally" or "split-billing" the professional component and the technical component.
- Billers must be knowledgeable about POS "22" and "19" for 1500!

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Ensure Claims are Compliant!

To re-state the obvious!

- If you are a physician changing to provider-based status –
- Educate not only billing staff members, but all departmental staff members about the different POS requirements for provider-based professional claims.
- And "why" POS is so important for accurate and "compliant" payment!
- The only way CMS can make certain the CPT-4 code is paid appropriately is based on place of service:

  Independent (free-standing) physician office = 11

  On-Campus Provider-Based Clinic (hospital OP) = 22

  Off-Campus Provider-Based Clinic (hospital OP) = 19

Never, ever, ever bill Medicare POS 11 in the PBC!

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Provider Based - Attestations

- Application for provider-based entity, or pre-approval by CMS is NOT required!
  - Eliminated by 2003 FY Inpatient Prospective Payment System regulations
- CFR 42, 413.65 now says <u>may</u> submit "attestation":
  - Notify CMS of provider-based locations
  - Hospital states that applicable requirements have been met
  - Attest to meeting obligations for provider-based operations
- May notify CMS of material changes
- Attestation of provider-based status, and meeting the requirements for PB is "voluntary."
- Per CMS, provider-based operations depend on hospital's self- monitoring process (until audited, that is!)

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Provider Based - Attestations

- **No official "attestation" form published**
  - **Use CMS "Sample Format" outline from Transmittal A-03-030, April 18, 2003**
  - **Send to MAC, with a copy to CMS Regional Office**
    - **On campus – supporting documentation not required (recommend sending anyway)**
    - **Off campus – supporting documentation required**
  - **MAC may make determination**
  - **RO should either approve or disapprove**

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Provider Based - Attestations

- **Benefits of submitting attestation:**
  - **CMS only recoups excess payment, if later found non-compliant**
  - **Triggers self-review of criteria**
  - **Provides written support of compliant process**
  - **Educates staff on requirements**
  - **CFR 42, 413.65 says – Provider "must" evaluate requirements and determine legality of provider-based entity.**
  - **"Not" provider-based just because Hospital believes to be!**
  - **Recommend filing attestation to meet compliant foundation for services.**

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Why File the Attestation?

Financial reasons for filing the provider-based attestation?

- **If CMS accepts the attestation following review, it will limit recoupment if the facility is later determined to be out of compliance.**
- **Without a reviewed attestation on file, CMS can recoup as far back as the applicable statute of limitations allows.**
- **If subsequent review determines that the criteria were not met, the additional money reimbursed due to billing as provider-based, rather than freestanding, will be recouped.**

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Provider-based Reimbursement

- Amount of, or even any, increased revenue is not automatic, varies by:
  - Specialty or type of clinical services to be provided
  - Payor mix
  - Volume of services
  - Rural vs. urban setting
- Recommend case specific analysis for each entity –
  - Compare current physician fee schedule (MPFS) payment to:
  - Hospital based payment (OPPS paid by APCs)
    - Additional cost for technical component
    - Physician professional component only
    - "Facility" RVUs

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Reimbursement Impact – the Good

- Reimbursement = increased cash outcome – generally!
- Under Outpatient Prospective Payment System (OPPS) and
- Ambulatory Payment Classifications – Usually pay more than MPFS
  - Comparison for procedure-based specialists generally reveal provider-based payment as greater than MPFS
  - Reflects historical reliance on cost built into APC system – 24/7 for 365 day operations and building / equipment investment make hospital more costly – thus reimburse more
- Reimbursement increase can be greater for CAH provider-based entities.
- Even greater for CAH based RHCs – historically

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Payment Example

- Medicare reimbursement for a Level III physician office visit (CPT-4 99213):

  Reimbursement:
  - In a freestanding Physician clinic: $ 68.21
  - In a Provider-Based Clinic:

    $48.29 + $90.94 (APC) = $139.23

- A provider-based RHC owned by a hospital with less than 50 beds is exempt from the per-visit reimbursement cap.
- The difference depends on the allowable costs of the RHC but those costs include costs allocated from the hospital.
- Please keep in mind – these are national payment rates, yours may (and probably will) vary!
- New considerations for 2018 due to "bundling" of outpatient services under OPPS!

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Why Would Anyone *Not* Want to Operate a PBC?

- **The reason the government pays more is because it costs more to operate a provider-based location than a free-standing physician clinic.**
- **In return for increased reimbursement, the CMS requires increased regulatory compliance – including a decreased risk of fraudulent billing.**
- **Physicians – particularly those who were in an independent practice prior to working in a provider-based site, perhaps even at the same location, are not always enthusiastic about increased regulatory oversight.**
- **It can seem (or even actually prove to be) more trouble than it is worth.**
- **The increased reimbursement often leads to increased expectations regarding physician compensation. *How does Medicare reimbursement in the PBC fit within the organization's existing physician compensation arrangements?***

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Reimbursement Impact – the "Not" so Good

- Significant portion of increase may be in **patient co-pay or patient responsibility portion of charge:**
  - 20% of hospital facility / technical charge for non-government payor patients
    - Actually for Medicare beneficiary under OPPS, APC co-pay is set amount depending on specific CPT-4 or HCPCS Level II code
      - May be more or less than 20% of charge
  - 20% of physician fee schedule for professional component
- **Consider possible negative effect of patient being responsible for two co-pays or co-insurance amounts**
    - May be covered by Medicare secondary policies

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Provider-Based Billing

- Medicare BILLING
  - Sometimes called “split” billing –
    - For Medicare, we are separating the hospital component of the service from the professional component, and
    - Submitting two (2) Medicare claims for the same patient for the same date of service
  - Hospital facility (technical) fee billed on a UB-04
  - Professional fee billed on a CMS 1500
    - unless CAH elects all-inclusive payment
  - Billed the same as traditional hospital-based physicians in Emergency Department, Radiology, Anesthesiology, Surgery, etc…

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Bill All Patients as Provider-Based?

- Private pay: **to bill or not to bill commercial / private payors as provider-based?**
  - All Medicare patients must be billed as hospital patients – 413.65(g)(5)
    - Have obtained CMS regional office confirmation that this does not apply to:
      - Medicare Advantage (HMO) patients and
      - Medicare secondary
  - Private pay point-of-care payment for provider-based services by patient may be significantly higher than “free-standing” service!
  - Arm staff members with scripts for appropriate explanation!

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Reality Provider-Based Billing?

Two Provider-Based Billing Choices:

- **Split bill all services to all payors** using the same two charges
  - one for the facility / technical component (paid by APC)
  - one for the professional component (paid by MPFS or other fee schedule based on CPT-4 code)
  - adjust off the charge for commercial insurance if payor does not recognize “0510” Revenue Code for facility component of Clinic services
- **Split bill only Medicare**, and establish a third “global” charge for the private / commercial payer.
- Medicare allows hospitals to bill private / commercial insurers as freestanding, even if they are provider-based.

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Provider Based Reimbursement

Payment Example

Illustration Only!
Your payment will be different!

Outpatient Visit (Office)

Level 3 -- 99213	Charge	Medicare Allowable	APC	Medicare Payment	Co-pay	
Free-standing Clinic	$ 300.00	$ 68.21		$ 44.57	$ 13.64	
Total Reimbursement						$ 68.21
Provider-Based Clinic						
Professional Fee	$ 200.00	$ 48.29		$ 38.63	$ 9.66	
Facility Fee	$ 100.00		$ 90.94	$ 90.94	$ 22.74 *	
	$ 300.00			$ 129.57	$ 32.30	
Total Reimbursement						$ 161.87

* 2018 OPPS (APC) Packaging may affect

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Provider-Based Benefits – In Practice

- Miscellaneous benefits or deterrences
  - 340-B benefits follow provider-based status – drugs used at P-B departments are eligible for 340-B discounts.
  - Residents in provider-based location (department) count for IME / DME FTE count
  - Physicians in outpatient departments as POS 22, but not I/P or ER (POS 21 & 23) count for EHR incentives
  - Cannot use Stark group practice compensation methodology for ancillary bonus pools
    - If docs employed by hospital, by definition not group practice
    - Medical Group, Inc., is group practice, BUT ancillaries will not be part of its business – will be in hospital

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Compliance for New Location

- **Any time a provider (hospital) adds a new service location, the provider is required to report it to the MAC within 90 days of the effective date of change, regardless of whether the provider is filing a provider-based attestation or not.**
- **Per 42 CFR 424.520(b), failure to report such changes within 90 days may result in the deactivation or revocation of the provider's Medicare billing privileges.**
- **These changes must be reported by submitting a CMS form 855.**
- ***File the 855 first so that it will have already been accepted by the MAC by the time any provider-based attestation is filed.***

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Do Hospitals Have to Employ the Physicians in the PBC?

- No – as long as the physician follows all the rules and bills all services to governmental payers under POS 22.
- It works in all other split billing situations!
- If the hospital is not billing for the physician, there has to be a contract requiring the physician to bill POS 22 AND a requirement that the physician will allow the hospital an opportunity to audit the physician's billing records.
- The hospital is responsible to Medicare even if the physician does the billing.
- If the physician is not employed, it increases the risk that some patients will be treated as "private" patients of the doctor and not admitted to the outpatient service of the hospital.
- ALL patients seen in the provider-based location must be admitted to the hospital, processed under the hospital medical record system, and protected by all the hospital policies mandated by Medicare under the Conditions of Participation.

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Remember EMTALA

- EMTALA does apply to off-campus hospital-based departments if it is deemed an outpatient department of the hospital by CMS, and a majority of patients seen are unnscheduled.
- This type of facility may include certain diagnostic facilities, clinics, primary care centers, outpatient therapy facilities, and urgent care facilities.
- EMTALA will not be imposed on other provider-based entities such as skilled nursing facilities (SNF) or Home Health Agencies (HHA) because they are distinct Medicare providers in their own right.
- If an individual presents to any facility located off a hospital's main campus and that facility has been determined to be a department of the hospital, then the hospital must provide, within its capabilities, an appropriate emergency medical screening examination and subsequent stabilizing treatment or conduct an appropriate transfer in keeping with EMTALA.

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Provider-Based Status

- Is it worth it?
- As suggested – perform the due diligence of reviewing this year's Medicare coverage of services, payment methodologies, and billing requirements!
- Follow claims submission closely – audit! To ensure compliance.
- Never take for granted that you know what information is being submitted on Medicare claims.
- Also follow payment receipt closely.
- Remember cost reporting requirements.
- Set an annual review for January each year to determine whether provider-based status is in the hospital's and the department's / clinic's best financial interest!

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Provider-based Billing

- Questions? . . .

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Revolutionize
Extend
Improve

Revolutionize your revenue cycle.

Extend your staff and IT assets.

Improve your bottom line.

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