



# Compliance TODAY

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an interview with  
**Lori Strauss**

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# Auditing compliance with CMS provider-based rules

- » Auditing provider-based status and space-sharing compliance is essential for hospitals.
- » Recent legislation and CMS guidance has impacted off-campus departments.
- » Ensuring compliance with provider-based status requirements protects existing off-campus locations.
- » CMS's interpretation of Medicare Conditions of Participation prohibits space sharing in hospitals. Excepted off-campus outpatient departments cannot relocate or be sold separately.
- » Hospital compliance professionals must focus on provider-based compliance.

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**D**o you know where all of your hospital's provider-based clinics are located within your community? Have you ever driven with your family and seen a building that you had no idea was part of your hospital or health system? Do patients

call in and complain, because they got a bill from ABC Hospital and swear they have never been there? If any of these scenarios describe your hospital or health system, then you need to keep reading!

It is critical that all aspects of the Centers for Medicare & Medicaid Services (CMS) provider-based rule<sup>1</sup> are understood and followed. Most of the provider-based rule's requirements are self-explanatory and can be easily complied with if you are operating as a provider-based department. Where things get challenging, however, is complying with the not-so-black-and-white informal guidance from CMS, such as from

telephone conversations with CMS representatives or conferences where CMS has presented on this topic.

## Basic principles

Despite ambiguity among these guidelines, there are a few basic principles to always keep in mind when reviewing provider-based compliance:

- ▶ Hospital space must be hospital space 24/7.
- ▶ Hospitals can't share any hospital space with non-hospital entities.
- ▶ If the hospital doesn't comply with *all* the provider-based requirements at the location, then the hospital is not entitled to hospital reimbursement as a provider-based department.

Getting your executive and leadership teams on board with these basic principles ensures they understand what they can and cannot do while remaining compliant with the provider-based rule. In particular, the recent changes in Section 603 of the Bipartisan Budget Act of 2015<sup>2</sup> (the Budget Act) affecting off-campus provider-based departments (OC-PBDs) have made this even more critical. Under the Budget Act, as of January 1, 2017, no



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OC-PBD may bill for hospital outpatient services under Hospital Outpatient Prospective Payment System (OPPS), unless (1) it is a dedicated emergency department or (2) it billed for covered outpatient services under OPPS prior to November 2, 2015, in which case the OC-PBD is “excepted” or “grandfathered.” Non-excepted locations currently receive 40% of the OPPS rate. CMS has recently indicated it is considering reducing payment at excepted locations for specified services and is seeking public comments on how to reduce payments for more services.

CMS proposed to reduce the payment rate for HCPCS Code G0463 Hospital Outpatient Clinic Visit to 40% of the OPPS rate and also proposed to pay 100% of the OPPS rate at excepted locations only for services furnished in the same “clinical families” as the location furnished during a “baseline period,” which is November 1, 2014, to November 1, 2015, for most locations. It remains to be seen whether CMS will finalize these proposed payment cuts.<sup>3</sup>

CMS has interpreted the Budget Act to mean that an excepted OC-PBD will lose its excepted status and no longer receive the full OPPS reimbursement if it relocates to a new address or is sold separately from the whole hospital. CMS created a narrow exceptions process to allow OC-PBDs that relocate due to extraordinary circumstances outside their control to continue to receive the full OPPS reimbursement, however.<sup>4</sup>

Due to the Budget Act changes, as well as CMS’s interpretive guidance, relocating excepted OC-PBDs may not be possible if the hospital wants to continue to receive 100% of the OPPS reimbursement for services furnished in the OC-PBD, unless the new location is excepted. If a move is from off-campus to “on-campus” (as defined below), however, OPPS reimbursement may continue, because the Budget Act changes affected only OC-PBDs rather than on-campus

departments. When planning any relocations, it is important to make sure leadership is aware that moving excepted OC-PBDs may result in reduced reimbursement.

### Auditing

It is very easy to read through a provider-based status attestation and conclude, “Yep, we comply and can check ‘yes’ in all the boxes.” But auditing compliance with provider-based status is more than just completing the attestation. Below are a number of key audit tips to help guide you and your leadership teams through the not-so-obvious requirements. But before you get started, get organized! Developing an audit template is imperative to staying organized and making the audit a success. Start by using the CMS provider-based attestation requirements as the basis of the template. A sample audit template is provided as Figure 1 (on pages 84-87) for your reference. The tips and the audit template provided are not intended to be an exhaustive list of compliance steps to meet the provider-based rule.

#### Audit tip 1: Locations

Create a master list of all provider-based departments. Do you even know where all of your provider-based departments are physically located and if they are on-campus or off-campus? CMS requires all on-campus departments to be within 250 yards of the main provider and all OC-PBDs to be within 35 miles of the main provider. Developing (and maintaining) a master list will help you determine the location of your departments; it will also help you determine which modifier must be used to bill for services furnished in each provider-based department (*See* Audit tip 4 for explanation of modifiers). In addition, if a provider-based department wants to move, you can determine the impact of moving on provider-based compliance and reimbursement.

Finding all of your provider-based department locations may seem easy, but many hospitals may not have a master list, requiring them to start from scratch. The following methods may help you to find all of your provider-based department locations:

- ▶ Review all of the hospital's real estate contracts to identify spaces you own or lease from another party. Who occupies these locations? Are hospital services provided there? If yes, add this location to your list.
- ▶ Obtain cost report data to identify locations where hospital costs are being allocated.
- ▶ Review your website to identify listed locations. Add these to your list if hospital services are provided at these locations.
- ▶ Review your accreditation documents to determine who and what is accredited under the main hospital.
- ▶ Review the departments built in your electronic medical record (EMR); make sure all the departments providing outpatient services are added to your master list.

The master list should include the address of the outpatient department, along with the hospital the department falls under within a larger health system. Once you have compiled your master list, compare the locations with your CMS-855 enrollment forms to confirm all locations have been added as appropriate. If you attempt to submit a provider-based attestation for a location that has not been added to your 855, the attestation will not be processed.

### **Audit tip 2: Public awareness**

Make it obvious to patients and the public that all provider-based department locations are part of the hospital. CMS requires that a provider-based department is held out to the public and patients as part of the main hospital. Although compliance with the public awareness requirement may seem easy, CMS requires more than a single sign that states the

location is part of ABC Hospital. To meet the requirement, it must be very clear to patients that they are physically located in hospital space at all times. For example, if a patient gets an X-ray while seeing an orthopedic physician, but upon receiving the bill, swears that he was never at the hospital, this could spark a patient complaint to a surveying body. Instead, a provider-based X-ray location must be specifically identified as part of the hospital. Hospitals should make sure all of the following clearly reflect to patients and the public that each provider-based location is part of the main hospital:

- ▶ **Media** – All brochures and advertisements (e.g., billboards, mailers, TV ads) must include the main hospital name.
- ▶ **Entryway signs** – Will patients realize when they enter a specific area of a multi-tenant building that they are entering a hospital department versus a physician office? All entrances must include the main hospital name and logo.
- ▶ **Way-finding signs** – All signs at the provider-based location should include the main hospital's name and logo.
- ▶ **Hospital website** – Especially for large networks in which there are multiple hospitals and provider-based departments, the website must include a description of the hospital with which the department is associated. Consider using language such as "a service of ABC Hospital."
- ▶ **Documents** – All documents printed from the provider-based department's EMR and any letterhead, emails, or other communications should include the name of the main hospital.
- ▶ **Telephone** – How are your staff answering the phones? Is the main provider mentioned when patients call, so they know they are calling (and perhaps scheduling an appointment with) a provider-based department of a hospital? Call all of your hospital provider-based departments to

ensure they are answering the phone in a manner that indicates it is a department of your hospital.

- ▶ **Staff uniforms** – Are staff wearing the same uniforms as the main provider and with the same logo?
- ▶ **Paperwork** – Make sure your signs match the name of the outpatient department submitted on your CMS-855 enrollment application.

Make sure the hospital's business development teams understand what the provider-based rule requires and, particularly, how to meet the public awareness requirement. In larger networks, the strategy is typically to market the network versus a single hospital or department. However, it is crucial that the main provider remains part of the marketing strategy and that it is obvious to the consumer which network locations are part of the main provider. Again, the patient needs to know that when they obtain services from a department of ABC Hospital, they will get a bill from ABC Hospital.

In the event your organization submits a provider-based attestation to CMS, CMS will require submission of actual pictures to prove compliance with the public awareness standard. If the pictures are not obvious in proving public awareness, CMS may request that changes be made to signs or other materials to be more obvious.

### **Audit tip 3: Space sharing**

Take a physical tour of the hospital's provider-based departments to identify any potential space sharing and signage concerns. Have you ever performed site visits of your facilities? If you haven't, plan to tour your sites to assure compliance! CMS has stated in informal guidance that hospital space must be hospital space 24/7, and that space "cannot be 'part time' part of a hospital

and 'part time' part of another hospital, ASC, physician office or other activity."<sup>5</sup>

It is often difficult to explain to leadership why space sharing doesn't comply, and to change existing non-compliant space sharing, because space sharing often makes sense from other perspectives. For example, putting a provider-based imaging department within a physician office seems more efficient for patients and physicians. However, CMS has indicated that this type of hospital-physician office integration doesn't work when it comes to complying with the provider-based rule, as well as the CMS Hospital Conditions of Participation.<sup>6</sup> If the department was surveyed, CMS would expect to see obvious separation of physical space, people, and processes between the hospital's provider-based department and the physician office. In essence, nothing should look or feel shared.

The best way to assess your risk and potential compliance implications with hospital space is to conduct site visits and tour your provider-based locations. Below are some items to identify, many of which are especially important in multi-tenant buildings:

- ▶ Is there a separate lobby/waiting room for the provider-based department?
- ▶ Is there a separate registration area for the provider-based department?
- ▶ Does a patient have to walk through a physician office to get to a provider-based department?
- ▶ Are there separate restrooms and supply closets?
- ▶ Is there clear demarcation of space in the form of permanent walls and doors?
- ▶ Is there a separate suite number for the provider-based department (i.e., an actual mailing address)?
- ▶ Is there appropriate signage throughout a building that may have multiple Medicare providers in the same building?
- ▶ Take a non-compliance employee on a tour. Ask them if they know where they

are (e.g., in a hospital department versus a physician office).

Another way to avoid potential compliance problems involving space sharing is to make sure you involve the right people on the team. As compliance professionals, we work with many individuals across the healthcare spectrum, but did you ever consider that working with an architect would be necessary? What about a construction team? These are the people leading the buildout of new facilities and changes to current space, and they are the liaisons with the architects who are drawing plans for new or improved space. It is crucial that these teams understand the provider-based rule and that shared space between a hospital and non-hospital is not permissible. So, where should you start if a new on-campus provider-based department is being proposed?

- ▶ View the blueprints and make sure there is clear demarcation of space as hospital space versus other space.
- ▶ Make sure there is no intent to share staff between hospital departments and other occupants.
- ▶ Make sure there is a budget for the signage requirements to clearly mark the applicable space as hospital space.
- ▶ Tour the space to see where, and if, permanent walls or doors can be erected to physically separate hospital space from other space.

#### **Audit tip 4: Hospital claims**

Understand the PN versus the PO modifier and when to use them, along with the appropriate site-of-service codes on Form 1500. Understanding when to use the provider-based modifiers is crucial to compliance and getting paid correctly for the services rendered in provider-based locations. More importantly, everyone who touches a claim should understand these modifiers. If not, the modifiers may not get applied appropriately, and your

facility could be at risk for submitting claims incorrectly and getting overpaid.

The PO modifier is used for excepted off-campus provider-based departments of a hospital, which means those locations meet an exception from the Budget Act's site-neutral payment reduction and should be paid under OPPS at 100%. For example, in an off-campus imaging location that was billing for covered out-patient services before November 2, 2015, modifier PO would need to be added to claims for the services rendered at this location.

The PN modifier is used to identify non-excepted off-campus locations, which are those locations that do not meet an exception to the Budget Act reduction. For example, a newly constructed imaging location opening after November 2, 2015, should use the PN modifier.

Here are a few points to review to assure provider-based modifiers are used correctly:

- ▶ Who notifies the charge description master (CDM) team of the correct modifier when a new location is added or relocated?
- ▶ Do all the people who "touch a claim" throughout the revenue cycle understand what these modifiers are for?
- ▶ Use the master list of provider-based locations identified to assure correct modifiers are set up at the department level of the CDM.
- ▶ Randomly review claims to assure the correct modifier was added when the claim was submitted.

When billing for professional services rendered in a provider-based clinic, the correct site-of-service must also be used. Incorrect site-of-service codes can impact payment and cause improper payments. This is often another area of confusion, because there are now three different possible site-of-service codes that could be used on Form 1500:

- ▶ 11: Physician Office – This should not be used when billing for a provider-based clinic.
- ▶ 19: Off-Campus Outpatient Hospital – This should be used when billing for any service provided in an off-campus clinic (regardless of whether it is excepted or not).
- ▶ 22: On-Campus Outpatient Hospital – This should be used when billing for any service provided in an on-campus clinic.
- ▶ Non-discrimination policy
- ▶ Notice of beneficiary co-insurance (include the form)
- ▶ 72-hour rule (bundling charges for outpatient services three calendar days prior to inpatient admission)
- ▶ Unified medical record and record retrieval
- ▶ Emergency Medical Treatment And Labor Act (EMTALA)
- ▶ Applying correct site of service

This is also an area that should be audited. Randomly review Form 1500 claims to make sure the correct site-of-service has been put on the claims.

Developing and implementing an approval process of any new hospital provider-based departments is key to compliance with all the requirements, along with assuring your executives understand the requirements of the provider-based rule.

#### **Audit tip 5: Audit policies**

Audit hospital policies to ensure all policies required in a CMS attestation are in place. You should use CMS's provider-based attestation form as your guide when auditing for provider-based compliance, understanding, however, that there is more to the attestation process than just checking items off the list. It is worthwhile to “pretend” that you are submitting an attestation to CMS and go through the process; there likely will be areas in which you are not as compliant as you thought you were.

For example, don't assume you have all of the necessary policies to assure compliance. CMS requires the submission of several policies with an attestation, conducts an inventory of all your policies, makes sure they are up to date, and confirms that the applicable staff knows about the policy. Below is a listing of policies that CMS expects with a provider-based attestation:

#### **Final thoughts**

Making sure that all provider-based and space sharing requirements are met in all locations, and particularly any excepted OC-PBDs, is more important than ever. With hospitals increasingly under financial pressure, keeping the full OPSS reimbursement in place whenever possible is essential. As a result, hospitals and health systems should ensure they understand the provider-based status and space-sharing rule and current CMS interpretations of the requirements. They should also have a robust compliance function in place that includes periodic audits of their provider-based departments to assure that all requirements continue to be met. Use the CMS attestation as your guide to self-monitor your organization's compliance with all of the provider-based standards. It is not a “one and done” situation—you must remain compliant! 📢

*At press time, the CMS final CY 2019 OPSS rule, referred to in endnote #3, had not been published. See Figure 1 on page 84.*

1. 42 CFR § 413.65 (Requirements for ... Provider-based Status)
2. Section 603, Bipartisan Budget Act of 2015, Pub. L. No. 114-74, 129 Stat. 584 (2015)
3. 83 Fed. Reg. 37046 at 37128 (July 31, 2018) CMS Calendar Year 2019 Hospital Outpatient Prospective Payment System Proposed Rule. Available at <https://bit.ly/2NEUFzR>
4. 81 Fed. Reg. 79562, at 79704, 79709 (Nov. 14, 2016). CMS Calendar Year 2017 Hospital Outpatient Prospective Payment System Final Rule
5. David W. Eddinger: Hospital Co-Location. American Health Lawyers Association webinar presentation, May 5, 2015. Available at <https://bit.ly/1zkVCjM>
6. 42 CFR, Part 485 (Conditions for Participation: Specialized Providers)

Figure 1 from “Auditing compliance with CMS provider-based rules” by Ilah R. Naudasher and Claire Turcotte on page 36.

Figure 1: Provider-Based Compliance Audit Checklist						
Documents Required	Provider-Based Department Name/Location					
	Department/Person Responsible	Date Requested	Documents Received Y/N	Action Items	Complete/Final Y/N	Comments
Provide your Annual Registration Report						
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 email from the State indicating a separate license is not issued for provider-based entities or a copy of the State regulation).						
Provide a list of key personnel (i.e., table of organization) working at the provider-based facility showing job titles.						
Provide list of all clinical staff (e.g., physicians, nurses, physical therapists, radiology technicians) 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.						
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.						
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.						
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.						
Provide a copy of the written policy in place that is used in record retrieval from both the main provider and the provider-based facility.						
Provide a copy of the appropriate section of the main provider’s chart of accounts showing that the facility is integrated with the hospital’s accounts and the entire trial balance that shows the location of the provider-based facility’s revenues and expenses within the trial balance. Clearly identify the cost centers on the trial balance.						



Documents Required	Provider-Based Department Name/Location					
	Department/ Person Responsible	Date Requested	Documents Received Y/N	Action Items	Complete/ Final Y/N	Comments
Provide a copy of the filed CMS Form 2552-10 cost report indicating the provider-based facility on worksheet A, line 90.						
Provide documentation that demonstrates the facility is held out to the public as part of the main provider. Examples of documentation that could satisfy this requirement are pictures of outside signage, entrance door, and interior. Mockup pictures are not acceptable. The pictures should be close enough to read the sign, yet far enough away to enable the viewer a concept of the entire environment. Include examples that show the facility is clearly identified as part of the main provider (e.g., shared name, patient registration forms, letterheads, advertisements, signage, website). Note: Advertisements that show the facility to be part of or affiliated with the main provider's network or healthcare system are not sufficient. Include letterhead or brochures that include the address and name.						
Provide a copy of the detailed floor plan of the facility with the provider-based space clearly marked as well as a floor plan of the building in which the provider-based facility is located.						
Provide a copy of the main provider's EMTALA (i.e., anti-dumping) policies. Provide written policies with respect to the off-campus departments for appraisal of emergencies and referral when appropriate.						
Provide staff policy to bill the site of service.						
Provide documentation that physician services furnished at the Center are billed with the correct site of services so appropriate physician and practitioner payment amounts can be determined. The Health Insurance Claim Form 1500 (OMB-0938-1197 Form 1500) is the preferred verification for site-of-service coding.						
Provide a copy of the facility's non-discrimination policy in accordance with the non-discrimination provisions in §489.10(b) of Chapter IV of Title 42.						
Provide the staff policy that all Medicare patients are billed as hospital outpatients and not as physician's office patients.						
Provide the staff policy for patients who received services at the hospital outpatient department and were admitted to the hospital as an inpatient.						



Documents Required	Provider-Based Department Name/Location					
	Department/ Person Responsible	Date Requested	Documents Received Y/N	Action Items	Complete/ Final Y/N	Comments
Please provide a notice of beneficiary co-insurance form with an estimated or actual co-insurance cost for services.						
Provide a copy of the policy regarding distribution of the Notice of Beneficiary co-insurance for the subject facility. The form and policy need to support the statement: "If beneficiary for any reason is unable to read and understand notice, the notice is provided to the patient's authorized representative prior to the delivery of service and, in situations where emergency service is required, notice is given as soon as possible after emergency situation is stabilized."						
Provide a copy of the potential charges used to complete the beneficiary co-insurance financial form.						
Provide written notice to the beneficiary of potential financial liability, and policy needs to support that: If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his/her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative; and in situations where emergency service is required, notice is given as soon as possible after emergency situation is stabilized.						
Provide the articles of incorporation and bylaws (aka code of regulations) for the main provider and provider-based facility if separate documents exist.						
Provide a copy of the provider-based facility lease.						
Provide a list of the key administrative staff (position/titles only) at the main provider and the provider-based facility that reflects a reporting relationship.						
Provide a copy of the organizational chart. The chart must include the main provider and the entity requesting provider-based status showing which department of the main provider the entity is included.						
Submit a written description of the facility director's reporting requirements and accountability procedures for day-to-day operation.						
Describe who has final approval for administrative decisions, contracts with outside parties, personnel policies, and medical staff appointments for the facility.						

Documents Required	Provider-Based Department Name/Location					
	Department/ Person Responsible	Date Requested	Documents Received Y/N	Action Items	Complete/ Final Y/N	Comments
A list of various administrative functions (e.g., billing services, laundry, payroll) at the facility that are integrated with the main provider. Also, include copies of any contracts for administrative functions that are completed under arrangements for the main provider and/or facility.						
A detailed map indicating the mileage separating the provider-based facility and the main provider to verify distance from the main provider to the entity seeking provider based status. An online service such as MapQuest may be used.						
A copy of any relevant management contracts for the facility						
Who owns the building?						
Date department originally opened						
Does the location have separate suite numbers?						
What is the department's suite number?						
Need copy of most recent HFAP/TJC Accreditation document						
Need copy of original 855A that was used for original address (if moved)						
Need copy of change of location 855A for new address						
Make sure main provider organization chart shows leadership responsibility at main provider and hospital off-campus outpatient departments (HOPD)						
Verify that all employees (e.g., nursing staff, leadership, administrative) of each department are employees of ABC Medical Center (and is identified on documents such as income/expense reports)						
Proof that all expenses are rolling to main provider						
Verify that all employees are paid from main provider						
Need copies of construction agreements (if applicable)						
Validate if any physician services are performed AND/OR billed from the HOPD						
Specific dates of opening at new location						
Determine who should sign attestation document (typically main provider CFO-or authorized official that signs 855's)						
Written certification from CEO or COO of the main provider that the department met the mid-build exception						
Does the location have a separate phone number (and do they answer the phone as a department of main provider?)						