

Why Should Providers Care about Provider-Based Billing and Reimbursement?

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Why Should Providers Care About Provider-Based Billing and Reimbursement?

Because money doesn't grow on trees



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What Do You Have to Do to Get the Money?

You have to follow some complicated rules



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Provider-Based Requirements

- Licensure
- Public Awareness
- Clinical Integration
- Financial Integration
- Billing
- Pros and Cons
- Proposed Repeal



Definitions

- Campus
 - Immediately adjacent to provider's main buildings
 - Within 250 yards of main buildings
 - Individual basis determined by CMS Regional Office
- Provider-Based Entity
 - Provider of health care services
 - Under ownership, administration and financial control of main provider
 - Both physical facility and personnel and equipment
- Provider-Based Status
 - Relationship between main provider and provider-based entity that complies with requirements

Compliance on Day 1

- Provider-based attestation process is voluntary and may be completed at any time
- Facility must be fully compliant with all of the provider-based criteria from an operational standpoint on **day one** of the operation of the provider-based facility
- If not, such services **cannot** be billed as provider-based until the facility becomes fully compliant with all provider-based criteria



Licensure: Ownership and Control

- Under ownership, administration and financial control of main provider
- Operated under the same license as the main provider
 - *Except* when State law does not permit under a single license
 - If State does not allow, then CMS will determine that facility does not have provider-based status

Public Awareness

- Held out to the public and other payers as part of the main provider
 - When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly
- Location/space must be clearly identified as part of main provider both with signage and other documentation
 - A shared name, patient registration forms, letterhead, advertisements, signage, website
- Advertisements that only show the facility to be part of or affiliated with the main provider's network or healthcare system are not sufficient - when patients enter the provider-based facility, they need to be aware that they are entering the main provider

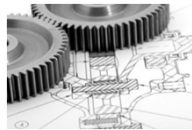
Clinical Integration

- Organization seeking provider-based status and the main provider are integrated as evidenced by the following:
 - Professional staff of the facility or organization have clinical privileges at the main provider
 - The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider



Clinical Integration *(continued)*

- The medical director of facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer of the main provider that has the same frequency, intensity, and level of accountability as exists with the main provider.
- Medical staff committees at the main provider are responsible for medical activities in the facility or organization.



Clinical Integration *(continued)*

- Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross-reference) of the main provider.
- Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.



Financial Integration

- Financial operations of the facility are fully integrated:
 - Shared income and expenses between the main provider and the facility
 - The costs of a facility that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility other than a hospital department are reported in the appropriate cost center of the main provider
 - Financial status of any provider-based facility is incorporated and readily identified in the main provider's trial balance
- Documentation maintained by the provider could include a copy of the appropriate section of the main provider's chart of accounts or trial balance that would show the location of the facility's revenues and expenses

Physician Place of Service Codes

- Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) **must be billed with the correct site-of-service** so that appropriate physician and practitioner payment amounts can be determined
- Hospital outpatient departments must comply with all the terms of the hospital's provider agreement
- Errors that might have gone undetected before when different FI processing Part A and Part B claims will now be easily discovered now that single FI is processing both
- If Medicare determines provider-based criteria are not met, fines and repayment

Split Billing

- CMS eliminated this split-billing requirement in revised §413.65(g)
- Medicare stated: we have decided to revise it to restrict the requirement for uniform billing to *Medicare patients only*, thus *allowing hospitals to bill other payers in whatever manner is appropriate under those payers' rules*.
- Hospital outpatient departments (other than RHCs) must treat *all Medicare patients*, for billing purposes, as hospital outpatients – cannot treat *some Medicare patients* as hospital outpatients and others as physician office patients

Split Billing

- Some commentators have noted that the conservative approach is to bill all payers (including self-pay patients) as it bills Medicare *unless* the payer will not accept the hospital's technical component charges or directs the hospital to bill otherwise
- Split billing satisfies the part of the provider-based regulation that requires "public awareness" further requiring that the provider-based site "must be held out to the public *and other payers* as part of the main provider"

Special note re: Medicare Secondary Coverage

- Billing for patients who have a commercial payer as a primary and Medicare as a secondary is challenging because of the two different charge structures (e.g. provider-based vs. freestanding)
- If the patient has Medicare as secondary, Medicare will not pay the technical fee unless the primary payer is billed using a split bill

Attestation: Yes or No?

- No longer mandatory – voluntary attestation
- Providers must comply with requirements of 42 CFR 413.65 and other applicable regulations
- If *CMS accepts attestation*, recoupment limited to time period since attestation if facility later deemed to be non-compliant
- If *no attestation* and subsequent review determines that criteria not met, then any additional money reimbursed due to billing as provider-based as opposed to freestanding, will be recouped
- CMS can recoup as far back as applicable statute allows without attestation

Why Operate a Provider-Based Entity?

- Medicare reimbursement is higher
 - Basic office visit
 - In a freestanding clinic \$ 64.14
 - In a Provider-based facility \$ 111.96



Why Not Operate a Provider-Based Entity?

- Government pays more because it costs more to operate a provider-based entity than a freestanding clinic
- Increased reimbursement means increased regulatory compliance by government
- Physicians are not always enthusiastic about increased regulatory oversight – may be more trouble than it is worth
- Increased reimbursement often leads to increased expectations regarding physician compensation

Possible Repeal

- 2013 Workplan
- OIG to determine extent to which practices using hospital or provider-based status met CMS billing requirements
- OIG to determine impact to hospital-owned physician practices billing as provider-based
- OIG noted in 2011 MedPAC expressed concerns about financial incentives presented by provider-based status and Medicare should pay similar amounts for similar services

Questions



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