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Auditing compliance with CMS provider-based rules

by Ilah R. Naudasher and Claire Turcotte

Ilah R. Naudasher (ilah.naudasher@ketteringhealth.org) is Network Director of Compliance Operations at Kettering Health Network inDayton, OH. **Claire Turcotte** (cturcotte@bricker.com) is a Partner in Bricker & Eckler's Cincinnati, OH office.

- linkedin.com/in/ilah-naudasher-993a76
- linkedin.com/in/claire-turcotte-3808a112

Do 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[1] 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[2] (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 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.[3]

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.[4]

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."[5]

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.[6] 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.

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:

- 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