

## **“Are You Provider-Based?”**

by

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### **Introduction**

Over the past two years, rehabilitation service providers have been struggling to conform to an ever-changing regulatory environment with respect to the Centers for Medicare and Medicaid Services' (CMS) requirements for provider-based entities. With each new issuance from CMS, however, the focus has become sharper. This article will clarify what is currently required of hospital-owned rehabilitation facilities.

“Hospitals” are commonly thought of as single entities. For Medicare billing purposes, however, the reality is quite different. Many, if not most, hospitals, do not consist of just one building. Hospitals commonly reside on “campuses,” where the main hospital building is surrounded by, and often physically connected to, a number of outlying facilities. The hospital may also own and operate “off-campus” facilities, such as outpatient clinics, physician offices, CORFs, and ASCs, which may be located many miles from the main hospital building.

Since the beginning of the Medicare program, hospitals have billed for services provided at both on-campus and off-campus facilities, as if they were part of the main hospital itself. The ability of hospitals to treat these facilities as part of the main hospital for Medicare purposes is very important for two reasons. First, the Medicare reimbursement for a hospital-owned and operated facility is often higher than that for a free-standing facility. Second, the patient's Medicare coinsurance payment for a hospital owned and operated facility is often more than copayment for services provided by a free-standing facility.<sup>1</sup>

Because of these important consequences, CMS has formulated criteria defining exactly which facilities may bill Medicare as “provider-based,” meaning as an integrated part of the main hospital. The regulations, however, go considerably beyond defining provider-based facilities. They impose significant compliance burdens on those facilities that wish to take advantage of provider-based billing.

### **Who Qualifies as Provider-Based?**

The provider-based regulations in their current “final” form went into effect on November 30, 2001.<sup>2</sup> The regulations define a “provider-based entity” as a “provider of health care services” or a rural health clinic “that is either created by, or acquired by, a main

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<sup>1</sup> As of January 1, 2002, the Medicare beneficiary copayment under the Hospital Outpatient Prospective Payment System was capped at 55%, as opposed to 20% under the Physician's Fee Schedule.

<sup>2</sup> 42 C.F.R. § 413.65 (66 Fed. Reg. 59856, Nov. 30, 2001).

provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider.” A “main provider” is defined as “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.”

While this definition of provider-based entities is quite expansive, the regulation specifically excludes from provider-based status a number of facilities. CMS has stated that the reason for these exclusions is that provider-based status would make no difference in the Medicare reimbursement for these facilities due to the fee schedule or Prospective Payment System (PPS) applicable to those facilities. The excluded facilities are:

- ASCs
- CORFs
- SNFs
- Hospices
- Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services
- Independent diagnostic testing facilities and any other facilities that furnish only clinical diagnostic laboratory tests
- Facilities that furnish only physical, occupational, or speech therapy to ambulatory patients, for as long as the \$1,500 annual cap on PT, OT and speech therapy remains suspended<sup>3</sup>
- ESRD facilities<sup>4</sup>

Recent communications from CMS have indicated that all entities or departments that are not on the list of specifically facilities from the requirement of obtaining provider-based designation, must meet the provider-based requirements in order to be reimbursed by Medicare as part of a hospital. This includes any facility that is located outside the “four walls” of the main hospital, regardless of whether that facility is on campus or off.

Thus most hospital outpatient rehabilitation departments—even if they are located on the hospital’s campus—will have to comply with the provider-based requirements. Since the regulations exempt from the provider-based requirements facilities that furnish only physical occupational, or speech therapy to ambulatory patients as long as the \$1,500 annual cap on coverage of physical, occupational, and speech therapy remains suspended,<sup>5</sup> some hospital outpatient rehab facilities will not be required to obtain a provider-based designation if their services are limited to physical therapy, occupational therapy and/or speech therapy. However, any outpatient department providing therapy

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<sup>3</sup> The suspension of the \$,1500 annual cap on PT, OT and speech therapy will expire after December 31, 2002, unless Congress enacts legislation extending the suspension or abolishing the cap.

<sup>4</sup> Provider-based determinations for ESRD facilities are made under separate regulations. 42 C.F.R. section 413.74.

<sup>5</sup> See note 2 above.

services other than those specifically excluded, such as respiratory therapy, will have to comply with the provider-based requirements, if they wish to take advantage of provider-based billing.

## The Regulatory Requirements

The provider-based designation application forms now in use by most CMS regions,<sup>6</sup> require facilities to establish to CMS's satisfaction that:

- The facility is located on the main hospital campus or within 35 miles of it, or, alternatively, that 75 per cent of the facilities patients reside in the same zip code areas as at least 75 per cent of the patients served by the main hospital, or that at least 75 per cent of the patients served by the facility who required the type of care furnished by the main hospital received that care from the main hospital<sup>7</sup>
- The appropriate reporting relationships exist between the facility's staff and the main hospital's administration
- The medical director of the facility maintains the appropriate reporting relationship with the chief medical officer of the main hospital
- The facility can be separately identified in the main hospital's Medicare cost report
- The patient records of the facility and the main hospital are fully integrated
- In its advertising, billing, and correspondence, the facility is held out to the public as part of the main hospital and not as a separate entity.

Provider-based facilities must also satisfy CMS with respect to:

- Compliance with the anti-dumping rules of the Emergency Medical Treatment and Active Labor Act (EMTALA)
- Ensuring that physician services are billed with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied
- Compliance with all the terms of the main hospital's provider agreement
- Ensuring that all patients are treated, for billing purposes, as hospital patients
- In the case of patients admitted to the hospital after receiving treatment in a hospital outpatient department, subjecting the patients' bills to the 3-day window (72-hour rule) applicable to the main hospital's PPS, and
- Compliance with the main hospital's health and safety rules.<sup>8</sup>

In addition, off-campus hospital outpatient facilities are required to furnish their patients with an advance notice of the patient's Medicare coinsurance liability. According to the

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<sup>6</sup> As of this writing, CMS has not decided whether it will maintain the current application process or adopt a "self-attestation" procedure for most provider-based facilities. Under either procedure, the supporting documentation that the facility will be required to provide to CMS will be the same. 67 Fed. Reg. 31483 (May 9, 2002).

<sup>7</sup> See 42 C.F.R. § 412.106. New facilities that are more than 35 miles from the main hospital may qualify if the facility is located in a zip code area that, for the preceding 12-month period, accounted for at least 75 per cent of the patients served by the main hospital. Facilities may also qualify if the facility is owned by a hospital or critical access hospital that has a disproportionate share adjustment greater than 11.75 per cent

<sup>8</sup> 42 C.F.R. § 413.65(g).

regulation, if the exact type of care and extent of service that the patient is to receive are known before the visit—as it may be with such treatments as physical, occupational, speech, or respiratory therapy—the notice must include the potential amount of the coinsurance liability. Even if the exact type or care and extent of service are not known beforehand, the notice must still explain to the patient that he or she will incur a coinsurance liability that he or she would not have incurred if the outpatient facility were not provider-based.<sup>9</sup> Note that this requirement applies only to *off-campus* facilities, as CMS assumes that patients arriving at on-campus facilities will realize that they are entering a hospital-based facility.

## Qualifying Deadlines

Under the current regulation, the basic deadline for existing facilities to file provider-based applications with CMS is October 1, 2002.<sup>10</sup> In addition, facilities that were treated by CMS as provider-based on October 1, 2000, either through a formal CMS determination or by virtue of the fact that the facility was billing and being paid as provider-based on that date, will continue to be treated by CMS as provider based until October 1, 2002.<sup>11</sup> Compliance with the filing deadline is critically important, because, if CMS should determine that the facility does not qualify for provider-based status, the timely filing protects the facility from liability for overpayments for the period preceding CMS's determination.<sup>12</sup> For facilities that qualify for the October 1, 2000 "grandfathering," CMS has proposed extending the filing deadline until the start of the main hospital's first cost reporting period beginning on or after July 1, 2003.<sup>13</sup> New facilities should include the provider-based application with their initial Medicare CMS Form 855 enrollment application.

## Conclusion

Because of the importance of provider-based status to facility reimbursement, and because of the imminence of the filing deadlines, the time for hospital-owned rehabilitation facilities to ensure their compliance with the provider-based requirements is now.

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<sup>9</sup> 42 C.F.R. § 413.65(g)(7). See note 1 above.

<sup>10</sup> 42 C.F. R. § 413.65(b).

<sup>11</sup> 42 C.F.R. § 413.65(b)(2).

<sup>12</sup> 42 C.F.R. § 413.65(j).

<sup>13</sup> 67 Fed. Reg. 31404, 31500 (May 9, 2002).