Provider-Based Rural Health Clinics

Charles A. James, Jr.

President and CEO

North American Healthcare Management Services

Overview

- Definitions
- Reimbursement Comparison
- Provider-based Criteria
- Offsite Locations
- Leased Employees/Management Contracts
- Penalties

Definitions

- PPS - Prospective Payment System: a Medicare payment system for short-term acute care hospitals.
- CAH – Critical Access Hospitals: receive Medicare payments at 101% of reasonable costs. (Lay term: RHC program for hospitals)

Definitions

- Provider-based Rural Health Clinic (PBRHC): an RHC which is owned and operated by a parent-entity. Usually a hospital.
- A PBRHC whose parent entity is a hospital with less than 50 beds (based on bed availability) is eligible for an un-capped encounter rate.

Clinic, Facility, Department?

42 413.65 (a)(2)

*"Department of a provider…f*or purposes of this part, the term "department of a provider" does not include an RHC or, except as specified in paragraph (n) of this section, an FQHC."

RHC Reimbursement

- Currently, independent RHCs are capped at $81.32 for 2016.
- The average provider-based RHC encounter rate (that we see!) is between $140.00 – 167.00.

PRBRHC: Parent Entity > 50 beds

There is no ***financial*** incentive to provider-based status for an RHC owned by a hospital fewer than 50 beds – for ***Medicare.***

Confirm the rate setting mechanism for RHCs with your state Medicaid agency.

Medicare Reimbursement Comparison

	Independent	Provider-based
Office Visit – 99213	$100.00	$100.00
RHC Encounter Rate	$80.04	$160.00
Medicare Payment (80% of RHC Rate	$64.03	$128.00
Patient Co-insurance	$20.00	$20.00
Total Payment	$84.03	$148.00

State Medicaid Reimbursement

- Medicaid agencies have many different rate setting mechanisms.
- Some states have their own cost reporting requirements.
- Some states use an average based on surrounding ‘like’ facilities.
- Others still just follow the Medicare Cost Report.

Diagnostic Testing and Lab: Provider-Based

- The professional component for X-Ray, EKG, and other diagnostic testing is bundled with the RHC encounter.
- The technical components for X-Ray, EKG, ultrasounds, etc. are billed to the FI using the parent entity's billing number.
- Lab services are also billed to the FI using the parent entity's billing number.

Provider-based Lab Claims

- PBRHC **owned by CAH**:
  - Billed using parent's outpatient provider number.
  - TOB 851/Rev Code 300/UB04
  - CPT and DOS on each line.
  - Payment based on parent cost report.

Provider-based Radiology-TC Claims

- PBRHC **owned by CAH**:
  - Billed using parent's outpatient provider number.
  - TOB 851/Rev Code 320/UB04
  - CPT and DOS on each line.
  - Payment based on parent cost report.

Provider-based EKG-TC Claims

- PBRHC **owned by CAH**:
  - Billed using parent's outpatient provider number.
  - TOB 851/Rev Code 730/UB04
  - CPT and DOS on each line.
  - Payment is cost-based.

PBRHC owned by PPS

- Billed using parent's outpatient provider number.
  - Lab: TOB 141/Rev Code 300/UB04
  - Rad-TC: TOB 131/Rev Code 320/UB04
  - EKG-TC: TOB 131/Rev Code 730/UB04
  - Payment is on Medicare Fee Schedule.

EKG/Diagnostic Services

	Amount	Description
Office Visit – 99213	$120.00	Clinic's Customary Fee
EKG (Interpretation and Report) – 93010	$50.00	EKG Professional Component
521 Rev Code Line Item	$170.00	Bundled RHC Encounter
93005 – EKG Tracing Only	$75.00	Billed by Hospital
Patient RHC Co-Insurance	$34.00	Co-Insurance From RHC Portion

Provider-Based Requirements

- Provider-based clinics are governed by CMS Program Memorandum A-03-030.
- This document delineates requirements for on-campus and off-campus (more than 250 yards from hospital campus) PB clinics.

Provider-Based Attestation

- Compliance with provider-based requirements is reported to the Medicare Administrative Contractor via ‘Provider-Based Attestation’.

When is Attestation Required?

In essence, submissions and reviews will only be allowed ***when there is a difference in payment or beneficiary liability***. When submitting an attestation, one of the questions that will be asked is, "what is the difference in payment between freestanding and provider-based status for this service?" If there is no difference, the attestation will immediately be closed with no recommendation made. (WPS PB FAQ)

Not Meeting PB Requirements

A facility is only allowed to bill as provider-based if they meet the various financial and clinical integration and other criteria as stated in the regulations. Although the attestation and review process to document that you have met those criteria is voluntary, the requirement that you meet the criteria themselves is still effective. If later review determines that the criteria were not met, there is the possibility that additional money reimbursed due to billing as provider-based, rather than freestanding, will be recouped.

(WPS PB FAQ)

OCR Compliance Per Clinic

"If you are a health care provider seeking initial Medicare Part A certification and or undergoing a change of ownership (CHOW), you need a civil rights clearance. The Centers for Medicare and Medicaid Services (CMS) will not certify you as a Medicare provider if you do not receive a clearance from OCR. (CMS) will not certify you as a Medicare provider if you do not receive a clearance from OCR." HHS Office for Civil Rights http://www.hhs.gov/ocr/civilrights/clearance/index.html

On-Site PBRHC

“For purposes of the provider-based regulations, "campus" means 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 CMS, to be part of the provider's campus.”

(CMS PM A-03-030)

Provider-based Criteria

- Licensure
- Clinical Services
- Financial Integration
- Public Awareness
- Obligations of hospital outpatient depts.
- Joint Ventures

Licensure

- Provider-based clinics must meet state facility licensing requirements.
- Some states (KY, LA) have a separate RHC license which is required.
- In addition to meeting licensure requirements, building, safety, and fire codes must be met.

LicensureDocumentation

- Provider Enrollment Summary Report(855A)
- A copy of a current State license of the main provider
- A copy of a current State license of the provider based facility or letter from the State indicating a state license is not required for the provider based facility

Location Documentation

- A map indicating the distance between the main provider and the facility.
- A description of the physical setting of the main provider and the provider based facility.

Clinical Services

- The professional staff at the clinic must have clinical privileges at the parent entity.
- The main provider maintains the same monitoring as all other departments.
- The medical director of the facility maintains the same reporting relationship to the chief of staff as other departments.
- The same professional staff committees at the parent are responsible for medical activities at the clinic (QA, utilization review, integration of services, etc).

Clinical Services

- 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 or organization 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. (CMS PM A-03-030)

Clinical Services Documentation

- List of Key personnel working at the provider based facility showing job titles and names of employer
- Organizational Chart
- Documentation to support the professional staff at the provider based facility have clinical privileges at the main provider
- Documentation or description that explains the level of monitoring and oversight of the facility by the main provider
- Documentation or description of responsibilities and relationship between the Medical Director of the facility, the Chief Medical Officer of the main provider, and the Medical Staff Committees at the main provider
- Documentation that inpatient and outpatient services of the facility and the main provider are integrated, and patient treated at facility who require further care have full access to all services of the main provider

Unified System of Retrieval

Documentation or written policy that explains how the medical records for patients are integrated into a unified retrieval system of the main provider

Financial Integration

The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. (CMS PM A-03-030)

Financial Integration

The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance. (CMS PM A-03-030)

Financial Integration Documentation

- A trial balance showing the location of the provider based facility's revenues and expenses in relation to other departments within the hospital.
- Documentation worksheet A of cost report documenting the integration of the expenses for the provider based facility
- The cost center of the facility on the Medicare Cost Report.

Public Awareness

- The provider-based clinic must be advertised as part of the parent entity.
- It's affiliation with the parent entity must be clear to the public.

Public Awareness

- Documentation that clearly reflects that the provider base facility is part of the main provider. When patients enter the provider based facility they are aware they are entering the main provider and are billed accordingly
- Provider letterhead, yellow pages, website, signs, advertisements, patient registration forms, etc.

Hospital Obligations

- Copy of the EMTALA policy of CFR 482.12(f)(1)(2) & (3)
- Documentation to support compliance with the antidumping rules of 42CFR 489.20(i),(m)(q), and(r), and 42CFR 489.24
- Documentation to support physician services furnished at the hospital based facility and billed with the correct site of service so that the appropriate physician and practitioner payment amounts can be determined. Copy of a 1500 or UB Claim. (RHCs exempt)

More Hospital Obligations

- Documentation that the facility complies with all the terms of the hospital's provider agreement.
- Documentation of compliance with the Non-discrimination provision in accordance with 42CFR489.10 (b).
- Documentation that all Medicare patients, for billing purposes, are treated as hospital outpatients and not as physician office patients.
- Documentation of a Payment Window provision policy applicable to PPS hospitals and excluded units.

Anti-Dumping Compliance

Documentation that when a Medicare beneficiary is treated in a hospital outpatient department that is located on the main providers campus and the treatment is not required to be provided by the antidumping rules, the hospital must provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability.

POS 72, 11, and 22

"(b) 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." (CMS PM A-03-030)

Non-Discrimination

Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with the non-discrimination provisions in §489.10(b) of chapter IV of Title 42.

42 CFR §489.10(b)

1. Title VI of the Civil Rights Act of 1964
2. Section 504 of the Rehabilitation Act of 1973
3. The Age Discrimination Act of 1975
4. Other pertinent requirements of the Office of Civil Rights of HHS

Payment Window Provisions

(f) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at §412.2(c)(5) of this chapter and at §413.40(c)(2), respectively.

NOTE: The payment window provisions do not apply to critical access hospitals (CAHs).

Health and Safety Rules

Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

Documentation maintained by the provider to document compliance with some of these requirements might include a copy of the EMTALA policy in place at the facility.

Off-Site Location Provisions

- The facility (RHC) is 100% owned by the main provider.
- The main provider and the facility have the same governing body.
- The main provider and the facility share the same governing documents.

Off-Site Location

The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the facility or organization.

Off-Site Location Admin/Supervision

- Key administrative staff (positions/titles only) at the main provider and the provider based facility that reflects reporting relationship.
- Organizational chart includes the main provider and provider-based facility and show which department of the main provider the entity is included.
- Description of the facility directors reporting requirement and accountability procedures for day to day operations.
- List of administrative functions at the provider based facility that are integrated with the main provider such as billing services, records, human resources etc…
- Copy of any contracts for administrative functions that are completed under arrangements for the main provider.

Operation, Supervision, and Control

- 100% ownership by parent entity.
- Same governance as parent entity.
- Same by-laws/organizing documents.
- Parent entity has full responsibility and final authority.
- Organizational structure and reporting requirements are the same as other departments of parent entity.

Distance Requirement

An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in §412.62(f)(1)(iii) of chapter IV of Title 42, and has fewer than 50 beds, as determined under §412.105(b) of chapter IV of Title 42, is not subject to the [location requirements]…of this PM.

Joint Ventures

In a joint venture, the PB entity:

(a) Be partially owned by at least one provider;

(b) Be located on the main campus of a provider who is a partial owner;

(c) Be provider-based to the main provider on whose campus the facility or organization is located; and

(d) Also meet all the requirements applicable to all provider-based facilities and organizations in §413.65(d).

Joint Ventures

"…where a provider has jointly purchased or jointly created a facility under joint venture arrangements with one or more other providers, and the facility is not located on the campus of the provider or the campus of any other provider engaged in the joint venture arrangement, no party to the joint venture arrangement can claim the facility as provider-based." (CMS A03-030 Transmittal)

Leased Employees

The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at part 414 of chapter IV of Title 42.

(CMS A03-030 Transmittal)

Providers and support staff

Main providers are not required to employ other support staff, such as maintenance or security personnel, who are not directly involved in providing patient care, nor are licensed professional caregivers such as physicians, physician assistants, or certified registered nurse anesthetists required to become provider employees.

No “Leased” Patient Care Staff

Other than staff that may be paid under such a Medicare fee schedule, the main provider may not utilize the services of “leased” employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

Location Requirements

- Off-campus facilities must be within 35 miles of the parent entity with EXCEPT:
  - Government entity or CAH with 11.75% disproportionate share.
  - 75% patients reside in same zip code as 75% of hospital patients.
  - RHCs attached to a main facility of fewer than 50 beds.

Management Contracts – Off Site locations

- Direct patient care staff are employees of the parent entity.
- Administrative functions are integrated with parent entity.
- Main provider has control over operations.
- Contract is held directly by parent entity.

Resources

- CMS Program Memorandum Change Request 2411. Transmittal A-03-030. April 18, 2003.
- List of Key Documentation. Provider-based Entities. Novitas Solutions Medicare JH.

  http://www.novitas-solutions.com/webcenter/portal/MedicareJH/page/pagebyid?contentId=00088266&_adf.ctrl-state=1df06cuzh6_55&_afrLoop=322944929638000#!

Links

Office For Civil Rights – Hospitals

http://www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication/index.html

Code of Federal Regulations - 42 CFR 413.65

https://www.law.cornell.edu/cfr/text/42/413.65

Contact Information

Charles A. James, Jr.

North American Healthcare Management Services

President and CEO

9245 Watson Industrial Park

St. Louis, MO 63126

888.968.0076

cjamesjr@narhsinc.com

www.northamericanhms.com