Provider-Based Entities:

Gina M. Reese, RN, JD, CPHRM
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Reese graduated magna cum laude from Whittier College School of Law in Los Angeles after receiving a bachelor’s degree in business administration with an emphasis in accounting, magna cum laude from California State University at Los Angeles, and with a nursing degree from Samuel Merritt Hospital School of Nursing in Oakland, California. After earning her nursing degree, Reese chose to specialize in pediatric intensive care and special procedure unit services in chemotherapy and diabetic care/education at University Hospital in San Diego and Children’s Hospital at Los Angeles (CHLA). She then moved into a position as supervisor in utilization management and quality review at CHLA, overseeing a cadre of nurses performing these tasks, staffing peer review and quality committees at the hospital, and drafting and managing policies and procedures for these activities. While attending law school, Reese accepted a senior-level position at Shriners Hospital for Crippled Children, Los Angeles, as the director of risk management, quality assurance, and utilization management.

After completing law school, Reese worked for 10 years as an associate attorney and later as a partner at Hooper, Lundy, and Bookman, a boutique health law firm in Century City, California, representing healthcare providers across the country. For the subsequent 10 years, Reese worked as senior counsel at Kaiser Foundation Health Plan/Hospitals, further broadening her knowledge of healthcare law to include managed healthcare, provider contracting, Medicare Advantage (including risk adjustment), revenue cycle, coding, privacy, electronic health records, and many other areas. Reese is now the risk manager at Methodist Hospital of Southern California.
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Billing for Provider-Based Entities: The Big Picture

Introduction

You have just taken a job as the hospital’s new revenue cycle leader after years of toiling away as a billing coordinator. One of your employees comes to you and states that she wonders whether the hospital is in compliance with the Medicare provider-based billing rules. Puzzled, you ask her where she heard this term. She states that her friends who work at a nearby hospital told her that the Medicare Administrative Contractor (MAC) is auditing that hospital for compliance with these rules in their infusion clinic.

You begin to panic. Do you or your coworkers know whether your hospital is in compliance? How do you go about auditing for compliance? Who is responsible—is it you? Why would this apply to an infusion clinic? What else do you not know?

Relax—billing for provider-based entities is not rocket science! Chances are you already know more than you think you do. Most provider-based billing concepts are common sense and based on big-picture concepts that you already know. However, you should pay attention to the details covered in the remaining chapters of this book and ensure compliance with them. There is a lot of evidence that the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) are increasing their scrutiny of compliance with these requirements. In addition, failure to be in compliance could be very costly and more time-consuming in the long run than auditing the hospital’s state of compliance now. For example, in the six months from October 2014 to April 2015 alone, two hospitals—W.A. Foote Memorial Hospital in Michigan and Our Lady of Lourdes Memorial Hospital in New York—self-disclosed and settled cases with the federal government for overpayments related to provider-based billing of $3.3 million and $2.6 million, respectively (Settlement Agreement between United States of America and Our Lady of Lourdes Memorial Hospital, 2014; Provider-Based Rules Trigger, 2015).
More investigations and repayments are likely to follow in the coming months and years, given the new tools implemented beginning in 2015 to more readily identify provider-based clinics. In addition, reimbursement for certain off-campus provider-based departments is being reduced, and hospitals must take care not to jeopardize payments for the other off-campus provider-based departments that are still being paid at the same rate under the hospital outpatient prospective payment system (OPPS).

We will go into great detail about all of the requirements in the following chapters, but it is helpful to first see the forest through the trees. The following is a summary of the big picture regarding billing for provider-based entities.

What Is a Provider-Based Department?

Provider-based billing is conducted by “main providers.” For Medicare purposes, a main provider is defined as any provider that either creates or acquires ownership of another entity to deliver additional healthcare services under the name, ownership, and financial and administrative control of the hospital (42 CFR §413.65[a][2]). While main providers include more than hospitals, the vast majority of provider-based entities are owned and operated by acute care hospitals and critical access hospitals (CAH). Therefore, we will primarily refer to hospitals as the main providers when we are discussing these requirements in this book.

Most simply put, provider-based departments are the locations where main providers furnish services to their own outpatients, as well as some remote locations and satellite facilities where hospitals furnish inpatient services. These locations are subservient and responsible to the hospital for all purposes, including oversight, control, clinical care, licensing, accreditation, and Medicare certification. Just like the main hospital, they must meet specific CMS requirements; these requirements are more onerous for provider-based departments located more than 250 yards off of the hospital campus (off-campus departments). We will interchangeably refer to “provider-based” and “hospital-based” when referring to the entities operated by main providers, since most provider-based entities are operated by hospitals. We may also interchangeably refer to provider-based “departments” in the upcoming chapters as “clinics,” “entities,” “settings,” and “locations.” Provider-based departments are not the same as freestanding physician offices or other entities that are separately licensed, accredited, or certified, even if those entities are located close to the hospital, furnish outpatient services to the same population of patients, and/or are owned by the hospital. The difference is that freestanding entities are considered to furnish their clinical services independent of the hospital and are responsible for independently meeting their own licensing and regulatory requirements.
Billing for Provider-Based Departments

As part of the hospital, services furnished in provider-based departments must be billed to Medicare and other government payers as services of the main provider. Billing for provider-based departments is generally accomplished through submission of two claim forms: one for the facility component and one for the professional component of the services.

The main provider (e.g., hospital) bills for the facility component of the services furnished in these provider-based departments on the (ASC) X12N 837I (Institutional) Version 5010A2 electronic claim form (837I) or UB-04 Uniform Bill paper claim under its own name and provider number, and it claims the costs for these locations on its own Medicare and Medicaid cost report. The coding for these services is no different from other hospital outpatient services, except for two new requirements: 1) beginning on a voluntary basis on January 1, 2015, and on a mandatory basis on January 1, 2016, the hospital must add the modifier “-PO” on each line item for services furnished in certain off-campus provider-based departments; and 2) beginning on January 1, 2017, the hospital must add the modifier “-PN” on each line item for services furnished in certain “nonexcepted” off-campus outpatient provider-based departments that are not reimbursed under the OPPS, in accordance with Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), enacted on November 2, 2015 (which amended the OPPS statute by amending section 1833(t)(1) of the Social Security Act, and adding a new paragraph (t)(21)), and implementing regulations found at 42 CFR §§419.22(v) and 419.48, enacted November 14, 2016 (see 81 Fed. Reg. 79562, 79699-79719 [November 14, 2016]).

The professional component of the services furnished in these locations is billed on a separate (ASC) X12N 837P (Professional) Version 5010A1 electronic billing form (837P) or CMS-1500 paper claim form (CMS-1500), using the standard Current Procedural Terminology (CPT®) codes for professional services. These services are billed by the physician or nonphysician practitioner (NPP) under the name and national payment identifier of the professional (or medical group) with the appropriate place of service (POS) code to show CMS that the services were furnished in a hospital outpatient department. Historically, professional services furnished to hospital outpatients in all provider-based departments would be billed using a POS of 22. However, CMS redefined POS 22 in Transmittal 3315, dated August 6, 2015. Effective January 1, 2016, POS 22 is used for professional services furnished to hospital outpatients only when the services are furnished on the main hospital campus (within 250 yards of the main hospital buildings). In the same transmittal, CMS introduced POS 19, which is to be used to bill professional services furnished to hospital outpatients in off-campus provider-based departments, also effective January 1, 2016.

In contrast, billing for services furnished in freestanding physician offices is performed using only one CMS-1500 claim form for the global service under the name and identifiers of the
professional or medical group operating the clinic. These claims are submitted with the POS code that identifies these services as being provided in the freestanding physician office (POS 11). Effectively, these services are billed on a global basis on one claim for all of these services, including the services of all ancillary, nursing, and physicians, as well as the overhead and supplies for those services.

Separately certified entities and facilities (e.g., home health agencies [HHA], skilled nursing facilities [SNF]) are billed separately from the hospital claim form on the billing form appropriate for that type of facility and under that entity’s provider/supplier number and name.

**Reimbursement for Services Furnished at Provider-Based Entities**

Services furnished by physicians and NPPs in freestanding physician offices and billed on the CMS-1500 form are paid to the professionals based on the Medicare physician fee schedule (MPFS). Because the physician is in effect billing globally for the entire service (both the facility and professional component of the service), he or she receives the entire fee schedule amount for the service.

In contrast, services furnished in provider-based departments are reimbursed separately to the professional and the main provider. The main provider (e.g., hospital) is paid only for the facility component of the services, which is billed on the UB-04 claim form. The facility component is intended to reimburse the hospital for the services of the hospital staff, supplies, and overhead necessary to operate the clinic and furnish the services.

The hands-on professional services of physicians and NPPs furnished to the patients in provider-based departments (billed on the CMS-1500 form) are still paid separately to the physicians/NPPs based on the MPFS. However, the physicians are paid a reduced portion of the MPFS amount to account for the fact that the services were furnished in the hospital outpatient department rather than in the physician’s office setting.

If you add up the facility payment made to the hospital and the professional fee paid to the physician, the total payment made by Medicare for services furnished in provider-based departments (the facility plus the professional components) has historically been higher in provider-based departments than the payment made for the same service furnished in a freestanding facility. This increased overall payment is attributable to a higher payment to the hospital (the physician’s payment is actually reduced under this system) and was designed to compensate the hospital for the higher overhead costs required to operate as the main provider, which is subject to more regulations than the freestanding physician clinic locations.
Due to the historically higher Medicare reimbursement to provider-based departments than the reimbursement to freestanding physician offices for exactly the same type of services, there has been increasing pressure on CMS by the Medicare Payment Advisory Committee (MedPAC), the OIG, and the public to equalize the payments for these services in these two settings of care. In reality, reimbursement for services furnished in provider-based departments has actually been significantly decreasing under the increased packaging concepts required under OPPS, which now mandates a single packaged reimbursement for clinic and emergency room visits and the vast majority of related ancillary services. However, this comes too late to halt the increased scrutiny by CMS of provider-based departments, especially those located off-campus, due to the historical criticism of this reimbursement by MedPAC, the OIG, and the public, as discussed in more detail later. As a result of these concerns, Congress enacted revisions to the OPPS effective January 1, 2017, that excludes most services furnished at certain “nonexcepted” off-campus provider-based departments from payment under the OPPS. Instead, these departments will be reimbursed based on the MPFS at a rate that is more similar to the reimbursement for independent physician office settings.

**Patient Cost-Sharing and Deductibles in Provider-Based Departments**

Medicare beneficiaries are charged a monthly premium for Part B services in addition to a small annual deductible. This deductible does not vary based on whether the beneficiary seeks services in a freestanding physician office or in a provider-based department.

Medicare beneficiaries are also liable for a coinsurance or copayment equal to approximately 20% of the Medicare allowable amount for each covered Part B service, with some exceptions. Beneficiaries who receive medical services at freestanding physician offices generally incur liability for only one copayment for the visit. This cost-sharing is based on the Medicare-allowed amount paid to the physician for these services.

In contrast, patients who seek the exact same services in a provider-based department receive bills for two copayments: one from the physician for the professional component of the services and the other from the hospital for the facility component of the services. The total amount paid by Medicare to the physician and the hospital for these services has historically been higher in a provider-based department than the total amount that would have been paid for these services in the freestanding physician office. Therefore, the beneficiary’s liability for these services has also generally been higher than the cost-sharing they would have been subjected to for these services at a freestanding physician office. On top of that, this increased liability has been more obvious to the beneficiaries because they receive two separate bills from the hospital and the physician.
Even though this differential has actually been decreasing over the past few years under the increased OPPS packaging concepts, Congress became concerned about the cost of these services to Medicare beneficiaries, which led to the recent law decreasing payment to certain provider-based departments, as discussed below and in later chapters.

Why the Government Is Concerned About Provider-Based Billing

Hospitals originated primarily to furnish inpatient services, since there were historically few outpatient services available other than minor treatments, dressings, and medications, and these services were furnished primarily in community physician offices and in the home. However, as technology has advanced, more complex outpatient medical services have become available, and these services have increasingly been provided in hospital outpatient departments.

The use of hospital-based clinics has rapidly increased in the past several years, as hospitals and physicians have recognized the advantages of vertically integrating their services. MedPAC analyzes Medicare spending for various types of services, as well as beneficiary access to services, in its annual review of each of the updated Medicare payment policy regulations. In its 2015 Report to the Congress, MedPAC examined the increasing shift of Medicare spending from freestanding physician offices to hospital outpatient departments:

> From 2012 to 2013, the use of outpatient services increased by 3.8 percent per Medicare FFS Part B beneficiary; over the past seven years, the cumulative increase was 33 percent. Roughly one-third of the growth in outpatient volume in 2013 was due to a 10 percent increase in the number of evaluation and management (E/M) visits billed as [hospital] outpatient services. This growth in part reflects hospitals purchasing freestanding physician practices and converting them into hospital outpatient departments (HOPDs). As hospitals do so, market share shifts from freestanding physician offices to HOPDs … From 2012 to 2013, hospital-based E/M visits per beneficiary grew by 9.4 percent compared with 1.1 percent growth in physician-office-based visits.

Other categories of services are also shifting to the higher cost site of care, such as echocardiograms and nuclear cardiology. Hospital-based echocardiograms per capita grew by 7.4 percent compared with an 8.0 percent decline in physician-office echocardiograms. Nuclear cardiology grew by 0.4 percent in HOPDs compared with a 12.1 percent decline in physician offices … From 2009 to 2013, the volume of E/M office visits provided to Medicare beneficiaries in HOPDs increased at an average annual rate of 9.2 percent, from 20.3 million visits to 28.9 million visits.

The government has been studying the increase in provider-based clinics for many years and has noted that hospitals are acquiring these clinics for various reasons. The OIG noted in 1999 that “[f]or hospitals, one of the major reasons to purchase physician practices is to establish physician networks to compete with managed care products being offered by insurance companies” (HHS OIG, Hospital Ownership of Physician Practices, OEI-05-98-00110, 1999). Other studies show that hospitals are increasingly employing physicians in order to gain market share, “typically through lucrative service-line strategies,” and to prepare “for expected Medicare reforms, including bundled payments, accountable care organizations (ACOs) and penalties for hospital readmissions” (Rising Hospital Employment of Physicians, 2011). Physicians reportedly are seeking integration with hospitals due to “stagnant reimbursement rates in the face of rising costs of private practice and a desire for better work-life balance” (Rising Hospital Employment of Physicians, 2011). MedPAC has also theorized that hospitals and physicians may be incentivized to operate provider-based clinics simply to increase payment for outpatient services (Medicare Payment Policy – Report to the Congress, 2015).

Anecdotally, it appears that hospitals may at times acquire or open provider-based clinics to ensure that certain medical services are consistently available for the patient population in the surrounding community. This is especially true in rural areas where it is difficult to attract medical specialists, who are likely to garner more income in urban areas. Teaching hospitals connected with universities may also wish to be able to offer a wide range of specialty outpatient medical services, to promote the hospital’s public visibility and brand name, and to promote research in specific medical areas by attracting top medical researchers. Hospitals may also be incentivized for other reasons: for example, the ability to count the medical residents in these departments in the hospital’s indirect medical education (IME)/graduate medical education (GME) full-time equivalent (FTE) count, the use of these hospital-based physicians to count as participants for the CMS Electronic Health Record (EHR) Incentive Programs, and the ability for nonprofit hospitals to purchase drugs at discounted prices under the Public Health Service Act 340B discount drug program for these locations.

Recent studies show that this trend is continuing. According to a report issued in September 2016 by the Physicians Advocacy Institute (PAI) in collaboration with Avalere Health, “[h]ospital ownership of physician practices has increased by 86% and the percent of hospital-employed physicians increased by almost 50% from July 2012 to July 2015” (Avalere Health Study, Physician Practice Acquisition Study: National and Regional Employment Changes, Prepared for Physicians Advocacy Institute, September 2016). In addition, the U.S. Government Accountability Office (GAO) noted that:

The number of vertically consolidated hospitals and physicians increased from 2007 through 2013. Specifically the number of vertically consolidated hospitals increased from about 1,400 to 1,700, while the number of vertically consolidated physicians
nearly doubled from about 96,000 to 182,000. This growth occurred across all regions and hospital sizes, but was more rapid in recent years.

—GAO, Increasing hospital-physician consolidation highlights need for payment reform, 2015

MedPAC raised concerns about this shift in medical care to hospital outpatient departments because:

Among other effects, the shift in care setting increases Medicare program spending and beneficiary cost-sharing liability because Medicare payment rates for the same or similar services are generally higher in HOPDs than in freestanding offices ... As more E/M office visits are provided in HOPDs, the higher payment rates in the OPPS relative to the physician fee schedule result in increasingly higher program spending and beneficiary cost sharing. For example, we estimate that the Medicare program spent $1 billion more in 2009 and $1.5 billion more in 2013 than it would have if payment rates for E/M office visits were the same in HOPDs and freestanding offices. Analogously, beneficiaries’ cost sharing was $260 million higher in 2009 and $370 million higher in 2013 than it would have been because of the higher rates paid in HOPD settings.


With this increased rate of payment from Medicare, beneficiaries have also raised concerns about higher patient financial liability for services furnished at provider-based departments. Most Medicare beneficiaries do not fully understand the reason for this increased cost, especially since provider-based clinics often appear to be nearly identical to freestanding physician offices, and there is no difference in the actual services received. As a result, beneficiaries have become increasingly vocal about the inequities they perceive in such a system. Therefore, MedPAC, CMS, and OIG have been put under more and more pressure to both explain the higher payments for services furnished in provider-based clinics and ensure that the services are justifiable.

As a result, MedPAC has for years recommended equalization of payments between physician office settings and hospital outpatient departments:

A greater concern is that the billing of many services has been migrating from physicians’ offices to the usually higher-paid HOPD setting. This migration has resulted in higher spending for the Medicare program and higher cost sharing for Medicare beneficiaries without significant changes in patient care. Therefore, payment variations across ambulatory settings should be immediately addressed. Although it is reasonable to pay higher rates in HOPDs for certain services, we have developed criteria to identify services for which payment rates should be equal across settings or the differences should be narrowed. We encourage CMS to seek legislative authority to implement our
recommendations to set equal payment rates for evaluation and management (E/M) office visits across settings and to align payment rates across settings for additional, select groups of services.

To move toward paying equivalent rates for the same service across different sites of care, in 2014 we recommended adjusting the rates for certain services when they are provided in hospital outpatient departments (HOPDs) so they more closely align with the rates paid in freestanding physician offices.


MedPAC gave some specific examples of the cost savings that would result from equalization of payment rates for the same services between freestanding and outpatient hospital departments:

For example, Medicare paid more than twice as much for a Level II echocardiogram in an outpatient facility ($492) as it did in a freestanding physician office ($228). This payment difference creates a financial incentive for hospitals to purchase freestanding physicians’ offices and convert them to HOPDs without changing their location or patient mix. For example, if a hospital purchased a cardiologist’s practice and redesignated that office as part of the hospital, the echocardiograms in that office would be billed as HOPD echocardiograms rather than physician-office echocardiograms, even if there were no change in the physician providing the service, the location of the physician’s office, or the equipment being used. In 2013, the volume of echocardiograms billed as HOPD services increased 7 percent, while those billed as physician-office services declined 8 percent. This type of shift to the higher cost site of care increases program costs and costs for the beneficiary. The Commission’s 2014 recommendation would reduce Medicare program spending, reduce beneficiary cost sharing, and create an incentive to improve efficiency by caring for patients in the most efficient site for their condition.


Because of the increased overall cost for provider-based services and the pressure from the public, CMS and the OIG are increasing their scrutiny of the billing for these services. The OIG and CMS are also openly questioning the appropriateness of paying more for hospital-based services overall and have begun to investigate whether these clinics are really incurring increased costs compared to independent physician offices.

In response to these criticisms, CMS did put in place a stricter regulatory structure around provider-based entities, especially off-campus departments. These regulations help ensure that these entities are truly operated as hospital facilities and not as independent clinics in disguise that are
inappropriately billing under the hospital to receive the higher provider-based payment. Because
the off-campus locations are more prone to problems, the criteria are even stricter for those enti-
ties. In addition, CMS and the OIG are increasingly enforcing these requirements.

CMS resisted the pressure from MedPAC to completely equalize the payments between these two
types of care settings for many years. However, CMS did take steps beginning on January 1, 2015,
to collect data on services furnished in off-campus provider-based departments, which were the
most controversial care settings, since they often appear to the public to be exactly the same as
independent physician offices, which are reimbursed at a lower rate. With the new -PO modifier,
voluntary for 2015 and mandatory for provider-based billing in 2016, as well as the new POS
code 19 required for professional billing for hospital outpatient services furnished in off-campus
locations in 2016, CMS began to gather all the information necessary to focus audits on hospitals
and physicians that are most likely to be billing in error. MedPAC applauded the use of these new
tools:

The proposal to collect data on services provided in off-campus provider-based
departments through the claims process may have some value in helping policymakers
understand the growing trend of hospitals acquiring physician practices. The inform-
ination may also help CMS verify that PFS [physician fee schedule] claims include the
correct site of service. However, the proposal does not address the fundamental problem
of unjustified payment differences between settings. The PFS payment rate is usually
higher when a service is provided in a nonfacility setting (such as a freestanding office)
than a facility setting (such as an HOPD). PFS claims for services furnished in provid-
er-based departments should indicate that the service was provided in a facility and
should therefore receive the lower facility amount. However, there may be cases where
the claim incorrectly indicates that the service was provided in a nonfacility setting. If
this occurs, CMS could use the proposed modifier to check whether the service was fur-
nished in a provider-based department and pay the appropriate rate.
—MedPAC comment, 2014

The OIG also concluded that CMS’ increased scrutiny and use of the -PO modifier was a step in
the right direction but claimed that those steps were not sufficient to curb overpayments for pro-
vider-based departments (Office of Inspector General, CMS Is Taking Steps to Improve Oversight of
Provider-Based Facilities, But Vulnerabilities Remain, OEI-04-12-00380, June 2016). The OIG came
to this conclusion after conducting a survey of 333 random hospitals to analyze compliance with
provider-based requirements, as well as studying documentation from another 50 hospitals that
reported owning provider-based departments but did not submit attestations to CMS regarding
them. The OIG then compared that data to CMS records to determine the efficacy of CMS’ over-
sight of provider-based clinics. The OIG concluded from this analysis that there were a number
of inefficiencies in CMS’ systems that restricted its ability to limit overpayments to hospitals that failed to meet provider-based requirements. Specifically, the OIG found the following limitations in CMS’ ability to manage payments to provider-based departments:

- CMS cannot identify all on- and off-campus provider-based billing locations because the claims data is obtained in an aggregate format.
- CMS may not be able to implement newly enacted reimbursement limitations because it is unable to segregate provider-based billing from other claims data.
- More than three-quarters of the 50 hospitals reviewed that had not voluntarily attested for the provider-based locations owned off-campus facilities that did not meet at least one of the provider-based requirements, which meant that the facilities were billing Medicare improperly and receiving overpayments, as well as improperly receiving overpayments from beneficiaries. This included failures to demonstrate that the facility was operating under the control of the main provider and that beneficiaries were notified of potential increased costs for obtaining services at that provider-based location.
- CMS has no independent method of calculating the amount of the overpayment made to these facilities.
- CMS reports that it often has difficulty obtaining the documentation requested to support attestation reviews.


The OIG reported that CMS failed to provide evidence that services in provider-based facilities furnished benefits that justified the additional costs to Medicare and its beneficiaries. Therefore, the OIG recommended that CMS eliminate the provider-based designation altogether, or at least eliminate any differential payment between provider-based departments and physician office settings. These were more radical steps than those recommended by Congress in the Bipartisan Budget Act of 2015. If CMS chose not to take these steps, the OIG recommended that CMS:

- Implement systems and methods to monitor billing by all provider-based facilities
- Require hospitals to submit attestations for all their provider-based facilities
- Ensure that regional offices and MACs apply provider-based requirements appropriately when conducting attestation reviews
- Take appropriate action against hospitals and their off-campus provider-based facilities that the OIG identified as not meeting requirements

CMS has not yet taken any of these recommendations. However, because CMS continued to support the differential payment scheme while data was being collected, Congress stepped in and enacted a law on November 2, 2015, that required CMS to take steps to reduce the reimbursement for many of these off-campus provider-based departments, especially for any of these locations acquired by hospitals after the date of the statute. The regulations implementing this statute were finalized and became effective January 1, 2017.

**So What Now?**

You have already taken the first step. The fact that you are reading this means that you have identified that you do not have all the information you need to know about provider-based entities, and you are ready to learn more and take on the task of assisting the hospital in auditing for compliance with these requirements. Now read on. You will soon gain expertise in provider-based billing and auditing for compliance in this area.

**References**


requirements. Well, doesn’t it make sense for the billing director to audit this? Aren’t these billing requirements?

Actually, that’s the wrong approach. Auditing for these requirements is a team sport. Hopefully, you have seen by now that very few of the provider-based compliance requirements are strictly about how to bill for these services. Instead, the vast majority of these requirements are clinical, organizational, and operational in nature. Therefore, all the hospital leadership and staff must be involved in compliance, from the frontline clinical staff, to the billing and coding staff, to the medical records department, to the executive suite, to the corporate board, and many staff members in between.

The first step in any compliance project this broad is to identify the necessary leaders for the team and others from whom input should be sought. As you review the prior chapters and the sample audit checklist at the end of this chapter (see Figure 7.1), you will see, at a minimum, that the following hospital and medical staff should be involved in this team effort, both to ensure compliance and to furnish documentation and information necessary to support auditing efforts:

- Governing body
- Executive leadership
- Chief compliance officer and departmental compliance officers
- Medical staff office and leadership
- Finance leadership, including those responsible for hospital cost-reporting
- Revenue cycle director
- Medical records/health information management leadership
- Administrator for the EHR
- Regulatory staff that manage licensing, accreditation, and certification applications/submissions
- Directors of utilization management and performance improvement/quality management
- Director(s) of facility management
- Admitting/registration director
- Administration and medical directors of each provider-based department
- Managers of contracted services
- Coders/billers—both professional and facility billing
- Physicians and nursing staff
• Legal counsel, as necessary, especially if there are joint ventures or management contracts

Although the managers and directors of the actual provider-based departments are important to the auditing efforts, the actual work of reviewing compliance should not be left strictly in the hands of those managers. It is not wise to trust the objectivity of managers reviewing their own departments. This creates the classic scenario where the fox is guarding the henhouse. However, even if the managers could be objective, any audit completed by the managers of the provider-based department would be incomplete, since they are not able to effectively judge the integration of these departments into the operation of the main provider. As noted above, this can be demonstrated and supported only by the other departments and high-level executives at the main hospital.

What to audit

After identifying the compliance team, the next step is to define the size and shape of the playing field. Although leadership should be able to readily identify the scope and location of all their own hospital operations, the reality is that they are often unable to accurately list all the various hospital departments and the legal character of these services. For example, the chief executive officer may be able to recognize that the hospital is affiliated with a clinic down the street but may not be able to correctly identify whether the services are furnished by hospital employees or under a management contract, or whether it operates as a freestanding clinic. In fact, hospital executives may not even be able to correctly list all the hospital operations. They may accurately identify large-scale operations but fail to remember all the related services and departments. Even the phlebotomy stations located in outlying buildings need to be mapped and reviewed. If the hospital does not know the details about the operations of its provider-based clinics, or fails to audit some of them, it is impossible to determine full compliance. Therefore, the first task in the audit is to create an accurate detailed list of the provider operations and actually map their physical locations.

This mapping exercise may be more difficult than it initially appears, because it is likely that no single staff member has access to all the information necessary to ensure a complete list of the hospital outpatient services. The first stop should be the facilities manager or similar person who is responsible for maintaining the building plans. Hopefully these plans contain details about all the hospital buildings, both on and off campus. However, many times these facility plans include only information about the buildings actually owned by the hospital and fail to include other locations leased by the hospital or operated under other types of arrangements. In addition, these facility maps may be outdated for various reasons, including rapid growth and recent acquisitions. The end result is that these maps may not be detailed, complete, or accurate enough to be the only source of information about the hospital facility services.
Another source of information for the mapping is the performance improvement, regulatory, and/or compliance leaders in charge of licensing, certification, and/or accreditation of the hospital services. This may include more than one person in larger and more complex hospital systems, which may have more than one accrediting and licensing agency (e.g., stroke, bariatric, psychiatric, other specialty services). These staff members are charged with furnishing lists of hospital services to regulatory agencies, which may be even more complete than the facility maps.

From this basic set of information, the team should develop both a physical map of the hospital facilities and a detailed laundry list of all the hospital services, both on and off campus. The map should identify the main hospital buildings, which are contiguous to each other, the buildings and other locations situated within 250 yards of the main buildings, and clinical departments located more than 250 yards off the main hospital campus. The map should also include any satellite facilities and remote locations operated by the hospital. The list of hospital departments should capture the following:

- Name/type of service(s) furnished in each location
- The actual physical address of these locations
- Whether the building is owned or leased
- The name and contact information of the landlord of any leased locations
- Whether the location is on- or off-campus, and, if off-campus, the distance from the main campus

This is a good time to start gathering and organizing the big-picture organizational documents from the main provider necessary to substantiate that the provider-based department is integrated with the main provider.

The last step in this first phase of the audit is an actual walk-through of all the hospital facilities and locations to verify the actual street address and services furnished at each location. During the walk-through, auditing staff should not only update the map and list of services but also ask about any services/locations not already on the map and begin the next phase of the audit—the collection of documents and other information necessary to complete the provider-based audit checklist (see Figure 7.1). The mapping and verification process may be quick and simple or lengthy and complex, reflecting the relative simplicity or complexity of the hospital operations.

**Auditing criteria**

As detailed in the sample audit checklist found at the end of this chapter (see Figure 7.1), the hospital staff should audit for compliance with each requirement under the provider-based regulations. As the staff works through the checklist, evidence of compliance should be collected from the department and organized in a compliance folder or notebook to memorialize the results of
the audit. At the completion of the audit, all this evidence should be scanned into an electronic file and updated as necessary as an ongoing compliance record to be produced in case of an external governmental audit. In addition, if the provider is planning to submit an attestation for some or all of the provider-based departments, some of this documentation will need to be submitted with the attestation, and the remainder must be maintained in the hospital records as support for the attestation and any subsequent audits.

Common Pitfalls in Provider-Based Compliance

Auditing for some of the provider-based criteria is fairly straightforward, but there are some common mistakes that hospitals have made that will be discussed below.

Failure to map and account for all provider-based spaces

Some providers are organized in a very simplistic fashion and change very little over time. These providers will have less difficulty completing a provider-based audit. For example, a stand-alone hospital with very few hospital outpatient services is unlikely to have any difficulty listing its provider-based departments and auditing them for compliance in a fairly rapid fashion. However, most hospital organizations are much more complex and are busily integrating both horizontally and vertically. As noted in Chapter 1, physician practices are increasingly integrating with hospitals. In addition, hospitals are consolidating into chain organizations through ownership, joint ventures, and other legal structures. As a consequence, a single hospital may have hundreds of distinct outpatient services, satellite facilities, and/or remote locations. To add to the complexity, the list of services furnished in a single hospital may rapidly and dramatically change from one year to the next. Therefore, despite the hospital’s best efforts, the staff may lose track of the location and number of services furnished by the hospital and, hence, may fail to ensure that these services are added to (and subtracted from) the hospital license and 855A in a timely fashion and that new locations are in compliance with the Medicare provider-based criteria.

As noted in Chapter 3, two of the threshold requirements for ensuring compliance with the provider-based criteria are addition of the location to the hospital license and submission of a revised CMS 855A with the address of the new hospital department. In addition, these requirements are essential to at least reducing the penalty if the other requirements are not met. With the rapidly changing environment described above, it is easy to see how these basic requirements could be missed.

Over and above the requirement to add any new provider-based location to the hospital license, there is also a requirement to report new service locations to the hospital’s MAC within 90 days of the effective date of the change, regardless of whether the provider is going to file a provider-based attestation (42 CFR §424.520[b], 2011). Failure to report such changes within 90 days
may result in the deactivation or revocation of the hospital's Medicare billing privileges. These changes must be made by filing a revised CMS 855A form with the hospital’s MAC.

Because of the risks associated with billing incorrectly in provider-based spaces, as well as failing to meet the CMS requirements to report revisions in service locations, hospitals should consider implementing a very rigorous process to manage any changes (additions or deletions) in hospital services (i.e., a change management process). This process would address various other concerns besides compliance with the provider-based criteria.

A mature change management process includes all important decision-makers and integrates a thorough approval and vetting of all new services and practice locations long prior to the actual acquisition of the service, construction of new buildings, or registration of any patients. Besides approval of the strategic plan and budget for the new service, the change management process should incorporate research into and compliance with regulatory requirements such as the provider-based requirements. By combining all these functions into one process, the hospital will be sure to bake compliance into the service and plan to set aside sufficient time to ensure that the location is not acquired and the service is not initiated until all the required applications are submitted and all compliance and regulatory approvals are received. A sample change management checklist is included at the end of this chapter (see Figure 7.2).

Similarly, the change management process should also be utilized for any revisions in the nature or location of hospital services. For example, when a hospital physically moves the location of a clinical department or service, the change management team should approve the planned move, ensure that the new location meets all regulatory and other requirements, and submit any applications for approval of this new location prior to the actual relocation of the department. These are considerations even when the hospital plans to terminate services or dispose of hospital buildings. Again, the change management decision-makers should ensure that the necessary changes are made to the hospital licenses, accreditation, and Medicare/Medicaid certification and that any other regulatory requirements are met in an integrated fashion. Finally, care should be taken in this decision-making process not to inadvertently lose the exception for a provider-based department under the new statute and regulations by temporarily or permanently relocating the department without consideration of the resultant lower Medicare reimbursement this will cause.

If this change management process is maintained in an ongoing fashion, there should be no need to perform periodic audits of compliance of the hospital services. Instead, compliance will be ensured as a required component of the strategic planning for all hospital operations. As a result, the hospital will always be prepared for an audit by the government and will not have to scramble to pull documents together at the last minute only to find that some important detail (like adding a department to the state license) has been overlooked.
**Sharing space with a freestanding entity**

As evidenced by multimillion-dollar settlements with the Office of Inspector General (OIG) and CMS by hospitals in 2011, 2014, and 2015, one of the biggest pitfalls in meeting the provider-based requirements is when a provider-based department shares space with a distinct freestanding entity (Denial of Hospital Off-Site Location, 2011; Settlement Agreement Between United States of America and Our Lady of Lourdes Memorial Hospital, 2014; Provider-Based Rules Trigger, 2015). CMS has been warning hospitals about this issue for several years and has begun recouping money paid to provider-based departments that make this mistake. For example, in a letter dated July 22, 2011, CMS determined that an entity failed to qualify as a hospital-based department for an Indiana hospital because, among other things, the entity shared space with a freestanding facility (Denial of Hospital Off-Site Location, 2011). CMS stated that sharing space with a freestanding entity violated the provider-based criteria in the following ways:

- **Does not meet definition of department of a provider.**

  To the extent that a facility does not meet the definition of a department of a provider [under 42 CFR §413.65(a)(2)], the facility cannot have provider-based status as a department of a provider. A department of a provider requires sufficient separation from any other facility. Sufficiently separated space is indicated by such features as exclusive entrance, waiting, and registration areas, permanent walls, and a distinct suite designation recognized by the United States Postal Service if the hospital department does not occupy an entire building.

  —Denial of Hospital Off-Site Location, 2011

- **Does not meet hospital CoPs.**

  When a would-be hospital department shares space with freestanding offices, CMS must consider the entire space that contains the purported hospital department and the space’s relationship to the hospital’s CoPs at 42 CFR Part 485 Subpart F … CMS may consider a suite in a medical office building to be a singular component for compliance with the hospital CoPs … However, CMS cannot consider only portions of a singular component when determining if these criteria are met … A main provider hospital may not lease or otherwise obtain use of a portion of a singular component within that space. Certain features, such as shared entryways, interior hallways, bathroom facilities, treatment rooms, waiting rooms, and registration areas are all indications that a purported hospital space may instead be a part of a larger component. Building plans that do not clearly demarcate a purported hospital space as a distinct space is another possible indicator that the space is not a self-contained component. Rent that is paid to a tenant of a building rather than directly to the
building owner or landlord may also be an indication that a space does not itself constitute a singular component.

—Denial of Hospital Off-Site Location, 2011

**Promotes abusive practices.**

Were CMS to permit hospitals to carve out spaces or services at freestanding facilities, hospitals and physicians would be able to make arrangements that would allow for the maximization of reimbursement for services depending on how certain services are reimbursed in certain settings.

—Denial of Hospital Off-Site Location, 2011

**Public awareness requirement not met.**

The public awareness requirement is not met to the extent that the singular component is held out as a freestanding supplier of services, even if it is also held out to the public as a furnisher of hospital services.

—Denial of Hospital Off-Site Location, 2011

CMS increased enforcement of its prohibition on sharing of space in 2014 and 2015. As discussed in earlier chapters, in addition to the case described above, the OIG has sought millions in repayments based on violations of the provider-based requirement due to sharing of space with freestanding entities. There are not yet a lot of details publicly available about the details in these cases, but one hospital settled a provider-based billing case for $3.37 million and another hospital reportedly settled a very similar case for $2.63 million—both based on the fact that the hospitals shared space with freestanding facilities (Settlement Agreement Between United States of America and Our Lady of Lourdes Memorial Hospital, 2014; Provider-Based Rules Trigger, 2015). Based on these cases, it is clear that CMS takes the issue of shared space seriously. Therefore, a hospital must ensure the following is true when conducting an audit:

- That hospital-based departments occupy an entire suite completely separate from any surrounding freestanding entities, including any entrances, hallways, and bathroom facilities
- That the rent for this location is paid to the building owner or landlord rather than to another tenant of the building
- That the freestanding entity does not borrow the space from the provider-based department during off-hours
- That the building plans completely support this separation
A walk-through of the hospital-based department both during the day and off-hours would be warranted to demonstrate that the space is not shared any time of the day or night.

**Failure to meet hospital outpatient coverage requirements**

There is an extensive list of coverage requirements that must be met to furnish outpatient services to Medicare beneficiaries, which we reviewed in some detail in Chapter 5. Hospitals may find that certain coverage requirements for therapeutic and diagnostic service are more difficult to meet than others, especially in off-campus provider-based departments. The following are some of the trickier issues that hospitals should audit more carefully in the process of monitoring for compliance in provider-based departments:

- **New therapeutic services without physician order or ongoing physician involvement.**
  
  A physician order is required to meet the Medicare coverage requirements, as detailed in Chapter 5. However, the nursing staff may not always obtain a physician’s order to perform all the therapeutic services furnished to Medicare beneficiaries. This is a common occurrence when nurses are treating patients under protocols for ongoing monitoring and treatment, where they may begin treatment of a new problem without first consulting with the physician and obtaining an order for the new services. For example, a nurse is furnishing treatment under the physician’s orders for a wound on the foot for three months and then notices a new wound on the lower leg and begins the same treatment for that wound without contacting the physician and obtaining orders for the new wound treatment. While the nurse may be correct about the need for these services, proceeding with the treatment without the physician’s order is not only a violation of the incident-to physician order rule but is also likely to be found a violation of the nurse’s state license scope of practice. Both of these issues could cause Medicare to find that these services are not covered and that the provider-based department is out of compliance. Reimbursement for these services may therefore be considered an overpayment.

  Be mindful of this issue in particular when auditing compliance in provider-based departments where nurses treat patients over a long period of time for chronic conditions. As noted above, nurses treating patients with chronic illnesses under protocols for ongoing monitoring and treatment often begin treatment of a new problem without first consulting with the physician and obtaining an order for the new services. Besides creating a problem under the physician ordering rule, this violates the requirement that the physician have periodic involvement with the patient and personally see the patient at the beginning of any treatment plan. The hospital must ensure that the nurses send the patients back to the physician for an assessment of the new or worsening condition, which will likely result in new orders for that condition.
In addition to auditing for therapeutic services performed without physician orders, consider establishing specific guidelines in chronic care clinics that require that:

- Patients be referred for a physician visit with any new clinical problems
- Patients be required to be personally seen by the physician at intervals specified by the medical staff for their condition
- Orders for the ongoing treatment be reassessed during the physician assessment and renewed only if still medically necessary

In addition, nursing staff must be mindful of obtaining orders for any new services and documenting all patient contact with the physician to demonstrate the physician’s ongoing oversight of the services.

- **Order by a physician with no hospital privileges.** As noted in Chapter 5, the physician or nonphysician practitioner (NPP) ordering therapeutic services must have clinical privileges at the hospital. There is a particular scenario that may cause insidious problems with this requirement. A physician may see a patient in his or her freestanding physician office and order a service that needs to be performed in the hospital provider-based department, such as an infusion service or transfusion. If this physician does not have clinical privileges at the hospital, his or her order for the services is not sufficient to meet the order requirement under the incident-to services. In this situation, the nursing staff is usually prohibited from accepting this order under the hospital’s bylaws, rules, and regulations. The nursing staff may not pick up on this point and may perform these services, because they are ordered by a physician. However, acceptance of this order may lead Medicare to determine that the service is not covered, and acceptance of payment from Medicare for this service may be considered an overpayment.

This is an important point to audit in reviewing compliance with incident-to requirements. In addition, the hospital may consider drafting a policy and procedure that requires nursing staff to check any new orders for services against a list of medical staff members and privileges to ensure that the order is from someone with clinical privileges at the hospital. There could be an automatic cross-check established within a hospital’s electronic health record to ensure that the orders received are from physicians with hospital privileges.

- **Supervision of hospital outpatient therapeutic and diagnostic services.** There are many potential pitfalls with the requirement that hospital outpatient services be supervised at the appropriate level under the incident to coverage requirements, as detailed in Chapter 5. These requirements should be audited closely, since they are highly scrutinized by CMS.
One of the requirements under the supervision rule is that the supervising physician or NPP must be available throughout the performance of the procedure. This requirement seems self-explanatory and, on the surface, does not appear to be difficult to implement. However, the challenge is ensuring that the physician or NPP is actually available during all the days of the week and hours of the day that the clinic furnishes services and does not disappear prior to the time the procedure is actually completed. For example, if a hospital-based clinic is open during the evening hours to accommodate patients who work during the day, the physician or NPP must also be available for those same hours. At times, the physician is available during the main portion of the procedures but not available during the time that the patient is recovering after the procedure. Services that must be supervised include both the actual procedure and any pre- and postprocedure recovery. Any mismatch in schedules may cause problems with this requirement. Therefore, you must audit the schedule of the supervising physician or NPP to ensure that there is a one-to-one match with the hours the services are furnished.

Under the current supervision rules for hospital outpatient diagnostic and therapeutic services, there is no limitation on the location of the supervising physician per se. As long as the physician meets the other requirements listed above, including the mandate that the physician be immediately available, the supervising physician or NPP may be located in the actual department, on the hospital campus, or in nonhospital property close to the hospital. This includes any location in a building off campus that houses multiple provider-based departments. However, as a practical matter, it is hard to understand how a physician or NPP could be located as far as CMS states is possible for supervision of hospital departments (off the hospital campus or in or near medical office buildings) and still be immediately available as described by CMS. It seems nearly impossible for a physician to be potentially miles off campus and still respond without a lapse of time.

Many hospitals, especially small facilities, struggle to find enough physicians who agree to supervise the hospital outpatient services. These hospitals would like to believe that the answer lies in using the emergency room physicians to furnish this supervision, since they are required to stay on the hospital campus to treat patients in the emergency department. However, use of these physicians could be challenged, since they are often tied up treating other patients and are therefore unable to actually respond immediately.

To my knowledge, there have been no real tests of how CMS will enforce these requirements, but the hospital should carefully audit this requirement. If possible, the hospital should consider drafting policies and procedures that mandate that the supervising physician or NPP remain as close as possible to the hospital outpatient department and not be involved in complex procedures with other patients so that he or she remains immediately available to step in and perform as required. Preferably, supervising physicians
should be directly assigned to the department, especially in busy off-campus provider-based departments.

In addition to the difficulties with the immediate availability of the supervising physician or NPP, hospitals often find it hard to demonstrate which physician is supervising the provider-based department at any one time. There are various methods of verifying that a supervising physician is present at a designated time, including, but not limited to:

- Maintaining a schedule of supervising physicians
- Instructing the nursing staff to document the name of the supervising physician in the encounter note
- Instructing the nursing staff to document the encounter in an electronic system that links the supervising physician with the billing system

Whichever method is selected, the hospital must perform an audit that verifies that the supervising physician documented in the system or on the schedule was actually available (e.g., was not on vacation, did not call in sick). In addition, it is useful to do a walkthrough audit of the provider-based clinics, especially those located off-campus. During this audit, the auditor may want to ask the nursing staff for the identity of the supervising physician or NPP and then call that physician or NPP to determine whether he or she can respond quickly enough to support the theory that this supervisor is actually immediately available, as required.

**Use of the correct POS code on physician billing for provider-based services**

As noted in earlier chapters, one of the basic requirements for compliance with provider-based billing is that the professional claims must be submitted on the CMS 1500 form using the POS for hospital outpatient services. POS code 22 must be used until the end of 2015. Effective January 1, 2016, POS code 22 will continue to be used for services furnished in on-campus hospital outpatient departments, but POS code 19 must be used when billing for services furnished in off-campus hospital departments. As detailed in Chapter 6, the hospital’s MAC and the OIG are easily able to audit whether the hospital-based physicians are correctly billing using the POS for provider-based locations. In fact, the OIG is carefully monitoring this issue, resulting in recoupment of overpayments made to physicians as the result of the use of the incorrect POS code.

The executive leadership may not believe that it is the hospital’s responsibility to ensure that the physician claims contain the correct POS coding for hospital-based outpatient departments (POS code 22). However, if the professional claims for services furnished in a provider-based department are generated with the incorrect POS code, this affects both the physician and the hospital. The physician may face recoupment of an overpayment (and possibly other penalties), but the hospital may also be found out of compliance with the provider-based requirements for that
Auditing for Compliance and Common Pitfalls

Clinic under 42 CFR §413.65(g)(2) (2011). In fact, CMS has expressly stated that both the physician and the hospital may be held responsible for ensuring that physicians and NPPs are billing correctly for hospital-based services:

*Physicians who practice in hospitals, including off-site departments, do so under privileges granted by the hospitals. Thus, we believe the hospital has a role in ensuring proper billing.*


Because of the high risk of noncompliance, a hospital operating a provider-based clinic must work closely with the entity that is generating the claims for the professional services furnished in that clinic to ensure that the POS code on those claims is 22 rather than 11.

In addition to concerns about the POS codes, there could also be problems with the professional claim if line items are included for the facility services furnished by the hospital outpatient department. As detailed in Chapter 6, these facility services must instead be billed by the hospital on the hospital claim. For example, if a diagnostic service is furnished in a hospital-based radiology department, and the interpretation is performed by a hospital-based physician, the professional claim may include only the professional component of the service and may not include the facility component of that service. If the professional claim also includes the facility component, this constitutes double billing for that service and may create doubt that the services were furnished in a provider-based department instead of a freestanding facility.

Given that the correct use of POS codes is one of the most readily audited requirements, this should also be one of the main criteria that hospitals audit on an ongoing basis if at all possible. Of course, if the professional services are billed by an agency that is distinct from the hospital billing services, auditing for this requirement is automatically more complex. Therefore, it is in the hospital’s best interest to become as involved as possible in billing for hospital-based physicians. At minimum, the hospital should consider sending annual letters to the physician billing service reminding them about the appropriate POS code for the hospital-based locations. Ideally, the hospital will actually contract to act as the billing agent for the physicians who furnish services in the hospital-based clinics. This gives the hospital more oversight and control of the professional claims and ensures better compliance with the provider-based requirements. The hospital must determine whether this means that it will prepare claims for these physicians just for services provided in the provider-based department versus billing for services furnished at all locations, including those outside of the hospital at freestanding facilities.
# Checklist for Audit of Provider-Based Departments

<table>
<thead>
<tr>
<th>Department Demographics</th>
<th>Dept. ____________</th>
<th>Dept. ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Department name.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2</strong> Physical address. Attach map of location and building plan for location.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3</strong> Type of services furnished.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4</strong> Furnishes inpatient or outpatient services (or both)? Explain.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5</strong> Space leased or owned by main hospital? If owned, attach any ownership documents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6</strong> If space is leased, list landlord and attach rental/lease contract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>7</strong> Distance from main hospital campus. Describe location, determination as to main hospital campus, and basis for determination of distance from that location. Attach map and any evidence used to make determination about distance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8</strong> Name of medical director at location.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>9</strong> Number and type of employees at location.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>10</strong> Name/title of department administrator/director at location.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>11</strong> Number of years and dates in operation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>12</strong> Does this department share space with another entity? If so, is it shared with hospital-based entity or nonhospital-based entity? Does the space overlap? Describe in detail and attach any pertinent information.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>13</strong> Are any of the department’s services furnished under agreement with another entity (e.g., management agreement or “under arrangements” agreement)? If so, with whom and describe. Attach agreement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>14</strong> Meets definition of “satellite facility” (provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital)? Explain.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Figure 7.1 Checklist for Audit of Provider-Based Departments (cont.)

<table>
<thead>
<tr>
<th>Provider-Based Department Info and CMS Criteria From 42 CFR 413.65</th>
<th>Dept. ______________</th>
<th>Dept. ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Meets definition of remote facility (furnishes inpatient hospital services in another location under name, ownership, and control of the main hospital)? Explain.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Who prepares the claims for the services from this location? Are the claims prepared by billers in the main hospital, contracted billing agency, or other? Explain in detail.</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Who employs the nonphysician staff in this department?</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Has the main provider filed a provider-based attestation for this department? If yes, list date(s) of attestation and attach attestation(s).</td>
<td></td>
</tr>
</tbody>
</table>

### Is This Location Exempt From Provider-Based Requirements?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Does this location furnish billable clinical services? If no, then explain and STOP—do not complete assessment (not required to meet provider-based requirements). If yes, proceed with remainder of assessment.</td>
<td></td>
</tr>
<tr>
<td>BB</td>
<td>Does this location have a separate Medicare provider number (e.g., hospice, home health agency, ambulatory surgical center, skilled nursing facility)? If yes, explain and STOP—do not complete assessment (not required to meet provider-based requirements). If no, proceed with remainder of assessment.</td>
<td></td>
</tr>
<tr>
<td>CC</td>
<td>Are the services furnished in this location billed under the hospital’s provider number and name? If yes, proceed with assessment. If no, explain the billing in detail and STOP here—this is a freestanding entity, not a provider-based department.</td>
<td></td>
</tr>
<tr>
<td>DD</td>
<td>Are all of the services furnished in this location provided by another entity “under arrangements?” If yes, explain, attach agreement, and STOP—do not complete assessment (not required to meet provider-based requirements). If no, proceed with assessment.</td>
<td></td>
</tr>
</tbody>
</table>

All Provider-Based Departments, Regardless of Location, Must Meet the Following Requirements a–ab (any “no” answers require remediation).
### Figure 7.1 Checklist for Audit of Provider-Based Departments (cont.)

<table>
<thead>
<tr>
<th>Provider-Based Department Info and CMS Criteria From 42 CFR 413.65</th>
<th>Dept. ____________</th>
<th>Dept. ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>a</td>
<td>Is this location listed on the main hospital’s state license (unless not allowed under state law, then enter “NA” and explain)? If listed on hospital’s license, attach hospital license.</td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Is this location listed as a hospital location on CMS 855A filed with Medicare Administrative Contractor? If yes, then attach 855A or other documentation that supports this conclusion.</td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>Is this location listed as a hospital department on the hospital organizational chart? If yes, attach organizational chart.</td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>Does the administrative manager of this department report up through the main hospital management structure? If yes, attach organizational chart or other evidence.</td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>Do all professional staff (physicians and non-physician practitioners) who furnish services at this location have clinical privileges at the main provider? If yes, attach documents supporting this conclusion.</td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>Does the medical director for this location report to the hospital’s medical director/chief medical officer? If yes, attach organizational chart or other documentation supporting this conclusion.</td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>Do the hospital medical staff committees supervise medical services at this location? If yes, attach documentation supporting this conclusion.</td>
<td></td>
</tr>
<tr>
<td>h</td>
<td>Do the hospital committees monitor/oversee the facility services at this location, including utilization management and PI/QA? If yes, attach documentation.</td>
<td></td>
</tr>
<tr>
<td>i</td>
<td>Is this department under the same bylaws and policies and procedures as the main provider? If yes, attach evidence.</td>
<td></td>
</tr>
<tr>
<td>j</td>
<td>Are the medical records at this location integrated with the hospital medical records (e.g., integrated electronic health record, medical records master patient index, or health information management retrievable cross reference to department records)? If yes, attach documentation supporting this conclusion.</td>
<td></td>
</tr>
</tbody>
</table>
### Figure 7.1 Checklist for Audit of Provider-Based Departments (cont.)

<table>
<thead>
<tr>
<th>Provider-Based Department Info and CMS Criteria From 42 CFR 413.65</th>
<th>Dept. ___________</th>
<th>Dept. ___________</th>
</tr>
</thead>
<tbody>
<tr>
<td>k  Do the outpatients at this location have access to services at the main hospital? If yes, explain conclusion, such as evidence of referrals of patients to main hospital.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>l  Is the cost center for this location found on the hospital general ledger, trial balance, and other financial reporting? If yes, attach examples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>m  Is this location reported on hospital cost report? If yes, attach examples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n  Do this location’s expense and revenue roll up to the main hospital’s income statement and balance sheet? If yes, attach examples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o  Are this department’s statistics and financials included in the main hospital’s annual Medicare and Medicaid cost report?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>p  Is this location held out to the public as part of the hospital on the hospital’s website, public advertising, and all other public documents? If yes, attach examples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>q  Do the department’s signage, letterhead, and advertising hold the location out as part of the main hospital? If yes, attach examples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>r  Does the reception staff at this location answer the phone and greet patients with a greeting signifying the department is part of the main hospital?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>s  Does the hospital phone book and internal and website listings include this department as part of the main hospital? If yes, attach examples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>t  Does this location meet all hospital Conditions of Participation, including life safety codes provisions? If yes, attach survey report showing that this location has been surveyed by outside surveyors or as part of an internal hospital mock survey.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Provider-Based Department Info and CMS Criteria From 42 CFR 413.65

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>u</td>
<td>Does the hospital ensure that services furnished at this location comply with the three-day payment window for Medicare beneficiaries (i.e., specified services provided up to three days before inpatient admission are included on inpatient claim) and one-day payment window for Medicaid patients? If yes, attach policies and procedures or other documentation to support this conclusion.</td>
</tr>
<tr>
<td>v</td>
<td>Are all patients at this location registered as outpatients of the main hospital? If yes, attach sample claims or other documentation showing evidence of this.</td>
</tr>
<tr>
<td>w</td>
<td>Does this location comply with EMTALA requirements (applies to on-campus departments and off-campus dedicated emergency departments)? If off-campus and not a dedicated emergency department, enter “NA.” If yes, attach evidence of emergency log, policies and procedures, and other evidence of compliance.</td>
</tr>
<tr>
<td>x</td>
<td>Are the professional services furnished at this location billed using the place of service code for hospital outpatient services (“22” for all services through December 31, 2015; effective January 1, 2016, “22” for on-campus departments, and “19” for off-campus departments)? If yes, attach sample of claims and P&amp;P supporting this conclusion.</td>
</tr>
<tr>
<td>y</td>
<td>Do the professionals at this location comply with nondiscrimination provisions? If yes, attach P&amp;P and any other evidence supporting this conclusion.</td>
</tr>
<tr>
<td>z</td>
<td>Do the services at this location comply with Medicare coverage rules, including the “incident to” requirements for outpatient services, for the services furnished in this location? If yes, attach policies and procedures and any other evidence supporting this conclusion.</td>
</tr>
<tr>
<td>aa</td>
<td>If the main provider is a nonprofit organization, does this department follow the main provider’s financial assistance and 501(r) requirements? If yes, attach evidence.</td>
</tr>
</tbody>
</table>
# Figure 7.1 Checklist for Audit of Provider-Based Departments (cont.)

<table>
<thead>
<tr>
<th>Provider-Based Department Info and CMS Criteria From 42 CFR 413.65</th>
<th>Dept. ____________</th>
<th>Dept. ____________</th>
</tr>
</thead>
<tbody>
<tr>
<td>ab If the location is operated under a joint venture with the main provider, is the location at least partially owned by one of the providers, is it located on the campus of the main provider who is a partial owner, and does it meet the provider-based requirements for that same provider? If so, attach evidence of meeting these requirements and attach the joint venture agreement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Department Is Off-Campus (Located More Than 250 Yards Away From Main Hospital Campus), the Department Must Also Meet the Following Requirements A–M (any “no” answers require remediation).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Is this department located within 35 miles of main hospital campus or, if not, does it meet one of the exceptions to this location requirement, such as a high degree of integration due to common patients between department and hospital (see 42 CFR 413.65[e][3])? If yes, attach map of location of department or evidence that it meets one of the other exceptions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Is the department located in same state as the main hospital (or in adjacent states only if allowed by state law)? If yes, attach map of locations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C Is this location 100% owned by hospital? If yes, attach documentation of ownership.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Is this location accountable to the same governing body as the main hospital? If yes, attach documentation supporting this conclusion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Does the location furnish a notice to its patients re: additional copayment for facility billing (see 42 CFR 413.65<a href="7">g</a>)? If yes, attach examples of notice(s).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F Does the main hospital have final approval over this department's administrative decisions, personnel actions, personnel policies, contracts with outside parties, and medical staff appointments? If yes, attach examples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G Are the services from this department billed through same billing system as other hospital services? If yes, attach evidence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H Is the payroll for the employees of this department paid through the main hospital payroll system? If yes, attach evidence.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Figure 7.1 Checklist for Audit of Provider-Based Departments (cont.)

<table>
<thead>
<tr>
<th>Provider-Based Department Info and CMS Criteria From 42 CFR 413.65</th>
<th>Dept. ______________</th>
<th>Dept. ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>I Are the supplies, drugs, and other purchases for this department made through the same place and follow the systems and procedures for the main hospital? If yes, attach evidence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Are the human resource services, benefit package, and salary structure for this department’s personnel furnished through the same department as the main provider? If yes, attach evidence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K Is this location directly supervised by the main hospital and under the same frequency, intensity, and level of accountability to the main provider as any other hospital department? If yes, attach support for this conclusion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L If this location is under a management contract, is the contract under the name of the main hospital and not a parent entity? Attach management contract.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M If the location is under a management contract, does the main provider employ the staff at this location (except for management staff or physician/nonphysician practitioners), or does the same organization employ the staff both at the main provider and this location? If yes, attach the management agreement and evidence of the employment of the staff.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Disclaimer: This is provided as a summary resource and does not substitute for qualified healthcare legal counsel review of appropriateness of provider-based status of each location.

Source: Gina M. Reese, RN, JD, CPHRM, an instructor for HCPro’s Medicare Boot Camp®—Hospital Version and Medicare Boot Camp®—Utilization Review Version. Reprinted with permission.
# Figure 7.2

**Hospital XYZ**  
Change Management Request Form

<table>
<thead>
<tr>
<th>Change Request #: ______________</th>
</tr>
</thead>
</table>

Instructions: Must be completed for any addition, revision, or deletion in clinical hospital services. Submitter completes Section A (General Information) for all submissions. Submitter also completes one of the following: Part B for request to add services/locations/departments; Part C for request for revision in services/locations/departments, including change in type of services, change of address; Part D for request for deletion or closure of services/locations/departments.

Change Management Committee: Based on submitted information, collect other information as necessary to ensure that all appropriate regulatory, information technology, financial, and other requirements are met for proposed revision.

## Part A: General Information

<table>
<thead>
<tr>
<th>Name of submitter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of submission (check one).</td>
</tr>
<tr>
<td>Addition/new clinical service:</td>
</tr>
<tr>
<td>Revision in existing clinical service:</td>
</tr>
<tr>
<td>Deletion of existing clinical service:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date submitted.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Brief summary of proposed change.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Proposed effective date of change.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sponsors of proposed change: List committees, executives, physicians, or others backing the proposal.</th>
</tr>
</thead>
</table>

## Part B: Addition of Services - Describe Proposed New Clinical Services in Detail Below

<table>
<thead>
<tr>
<th>Type of services (e.g., dialysis, infusion).</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Department name.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reason for change. Describe in detail if change is proposed to meet financial, clinical care, regulatory, or other need/requirements.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physical address. Attach map of location and building plan for location.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Furnishes inpatient or outpatient services? Or both? Explain.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Space leased or owned by main hospital? If owned, attach any ownership documents.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If leased, list landlord and attach rental/lease contract.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Distance from main hospital campus. Describe location, determination as to main hospital campus, and basis for determination of distance from that location. Attach map and any evidence used to make determination about distance.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of medical director at location.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Number and type of employees at location.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name/title of department administrator/director at location.</th>
</tr>
</thead>
</table>
### Hospital XYZ Change Management Request Form (cont.)

<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will this department share space with another entity?</td>
<td>If so, shared with hospital-based entity or nonhospital-based entity? Does the space overlap? Describe in detail and attach any pertinent information.</td>
</tr>
<tr>
<td>Are any of the department’s services furnished under agreement with another entity (e.g., management agreement or “under arrangements” agreement)? If so, with whom and describe. Attach agreement.</td>
<td></td>
</tr>
<tr>
<td>Meets definition of “satellite facility” (provides inpatient services in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital)? Explain.</td>
<td></td>
</tr>
<tr>
<td>Meets definition of “remote facility” (furnishes inpatient hospital services in another location under name, ownership and control of the main hospital)? Explain.</td>
<td></td>
</tr>
<tr>
<td>Who prepares the claims for the services from this location? Prepared by billers in main hospital? Or contracted billing agency? Or other? Explain in detail.</td>
<td></td>
</tr>
<tr>
<td>Who employs the nonphysician staff in this department?</td>
<td></td>
</tr>
<tr>
<td>Is a state license required for this location? If so, attach the application and list lead time for approval.</td>
<td></td>
</tr>
<tr>
<td>Must this service be added to the Medicare 855A/certification? If so, attach form and list lead time for approval.</td>
<td></td>
</tr>
<tr>
<td>Does this service require any special certification, accreditation, or any other special approval? If so, attach required form and list lead time for approval.</td>
<td></td>
</tr>
<tr>
<td>Part C: Revision of Services - Describe Proposed Revision in Clinical Services in Detail Below</td>
<td></td>
</tr>
<tr>
<td>Type of services (e.g., dialysis, infusion).</td>
<td></td>
</tr>
<tr>
<td>Department name.</td>
<td></td>
</tr>
<tr>
<td>Furnishes inpatient or outpatient services? Or both? Explain.</td>
<td></td>
</tr>
<tr>
<td>Reason for change: Describe in detail if change is proposed to meet financial, clinical care, regulatory, or other need/requirements.</td>
<td></td>
</tr>
<tr>
<td>Describe proposed change in detail (e.g., change in location, services).</td>
<td></td>
</tr>
<tr>
<td>If relocation, list current and proposed physical address. Attach map of location and building plan for location.</td>
<td></td>
</tr>
<tr>
<td>Space leased or owned by main hospital? If owned, attach any ownership documents.</td>
<td></td>
</tr>
<tr>
<td>If leased, list landlord and attach rental/lease contract.</td>
<td></td>
</tr>
</tbody>
</table>

---

(continued)
### Hospital XYZ
Change Management Request Form (cont.)

<table>
<thead>
<tr>
<th>Distance from main hospital campus. Describe location, determination as to main hospital campus, and basis for determination of distance from that location. Attach map and any evidence used to make determination about distance.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the change require regulatory approval? If so, attach application for change and list lead time for approval.</td>
</tr>
</tbody>
</table>

### Part D: Deletion of Services - Describe Proposed Deletion of Clinical Services in Detail Below

<table>
<thead>
<tr>
<th>Type of services (e.g., dialysis, infusion).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department name.</td>
</tr>
<tr>
<td>Furnishes inpatient or outpatient services? Or both? Explain.</td>
</tr>
<tr>
<td>Reason for change: Describe in detail if change is proposed to meet financial, clinical care, regulatory, or other need/requirements.</td>
</tr>
<tr>
<td>Describe proposed change in detail (e.g., change in location, services).</td>
</tr>
<tr>
<td>Does the change require regulatory approval? If so, attach application for change and list lead time for approval.</td>
</tr>
</tbody>
</table>

### APPROVAL OF PROPOSED CHANGE IN CLINICAL SERVICES

<table>
<thead>
<tr>
<th>Approving department</th>
<th>Signature and date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director of department</td>
<td></td>
</tr>
<tr>
<td>Head of change management committee</td>
<td></td>
</tr>
<tr>
<td>Compliance officer</td>
<td></td>
</tr>
<tr>
<td>Chief financial officer</td>
<td></td>
</tr>
<tr>
<td>Chief executive officer</td>
<td></td>
</tr>
<tr>
<td>[other approvals as necessary depending on type of proposed revision]</td>
<td></td>
</tr>
</tbody>
</table>

Disclaimer: This is provided as a summary resource and does not substitute for qualified healthcare legal counsel review of addition, revision, or deletion of clinical services, departments, or locations.

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Chapter 7

References


Gina M. Reese, RN, JD, CPHRM

Provider-Based Entities: A Guide to Regulatory and Billing Compliance, Second Edition, is a comprehensive guide to provider-based departments, including qualifying under CMS, unique billing and coding rules, and the business decisions behind owning or acquiring a provider-based clinic. It explains the effect an entity’s location and services have on its ability to operate and attest as provider-based and covers threshold requirements for this unique provider type, as well as more stringent requirements for off-campus clinics and departments.

This book breaks down complex Medicare coverage requirements and provides insight about recent coding and billing changes, including the introduction and use of modifiers -PO and -PN, new place of service codes, billing for excepted and nonexcepted off-campus clinics and departments, and determining excepted and nonexcepted status. It also offers practical advice for helping patients understand the relationship between hospitals and provider-based entities and how this may affect treatment and services.