

**OCH Patient Finance Manual**  
**Section 13. Provider Based Clinics**

OCH owns and operates a number of on-campus and off-campus outpatient departments and off-campus facilities that qualify as provider-based under CMS regulations. These departments and facilities are integrated within the hospital organization in the same manner and to the same extent as all hospital outpatient departments. The process under which the hospital obtains provider-based status and the regulations applicable to the operation of each provider-based department or facility is described in the following provisions. Regardless of whether they are grandfathered under BIPA, providers are not obligated to submit attestations or applications for provider-based status before they begin billing as provider-based. A provider would only be considered to be billing inappropriately if the facility actually did not meet the relevant provider-based rules. However, if a provider does not submit a complete attestation acceptable to CMS of provider-based status, and CMS subsequently determines that the provider is billing inappropriately, the provider would be subject to recovery of overpayments for services at that facility for all prior cost reporting periods.

**13.1. Criteria at §413.65(d) applicable to all provider-based facilities:**

**13.1.1. Licensure:** The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license. Documentation maintained by the provider may include a copy of the State license, including the license number and the expiration date. Where applicable, the provider may need to maintain documentation of whether the State where the entity is located requires a separate license for the facility requesting provider-based status.

**13.1.2. Clinical Services:** The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

- (a) Members of the professional staff of the facility have clinical privileges at the main provider.
- (b) The main provider maintains the same monitoring and oversight of the facility as it does for any other department of the provider.
- (c) The medical director of the facility maintains a reporting relationship with the chief medical officer of the main provider.
- (d) Medical staff committees at the main provider are responsible for medical activities in the facility, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility and the main provider.

Documentation maintained on (a)-(d) may include a list of all personnel working at the facility showing their job titles, information as to whether professional staff of the facility have clinical privileges at the main provider, a description of the level of monitoring and oversight of the facility by the main provider as compared to oversight for another departments of the main provider, and a description of the responsibilities and

relationships between the medical director of the facility, the chief medical officer of the main provider, and the medical staff committees at the main provider.

(e) Medical records for patients treated in the facility are integrated into a unified retrieval system (or cross-reference) of the main provider. The provider may maintain a copy or description of the policy utilized in record retrieval from both the main provider and the facility requesting provider-based status.

(f) Inpatient and outpatient services of the facility and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

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

**13.1.4. Public Awareness:** The facility seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility, they are aware that they are entering the main provider and are billed accordingly. As documentation, the provider may maintain examples that show that the facility is clearly identified as part of the main provider (i.e., a shared name, patient registration forms, letterhead, advertisements, signage). Advertisements that only show the facility to be part of or affiliated with the main provider's network or healthcare system are not sufficient.

**13.1.5. Obligations of Hospital Outpatient Departments:** In the case of a hospital outpatient department, the facility must fulfill the obligations of hospital outpatient departments as described in §413.65(g)(1) through (6) and (g)(8). These obligations include:

(a) Hospital outpatient departments located either on or off the campus of the hospital that is the main provider must comply with the antidumping rules in §§489.20 (l), (m), (q), and (r) and §489.24 of chapter IV of Title 42.

(b) Physician services furnished in hospital outpatient departments or hospital-based entities (other than a RHC) must be billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined.

(c) Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

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

(e) Hospital outpatient departments (other than a RHC) must treat all Medicare patients, for billing purposes, as hospital outpatients. The department must not treat some Medicare patients as hospital outpatients and others as physician office patients.

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

**13.2. Content of Attestations for Off-campus Facilities:** If the facility is not located on the main campus of the main provider, the provider must submit an attestation containing the identifying information described in 13.2 and state that its facility meets each of the criteria in paragraph C.1 through C.4 (corresponding to regulations at §413.65(d)) as well as the additional requirements listed below (corresponding to regulations at §413.65(e)). The hospital also must attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph C.5 and item 4 of this paragraph (corresponding to §413.65(g)). The provider seeking such a determination must submit documentation of the basis for its attestations to CMS at the time it submits its attestation. The additional requirements applicable specifically to off-campus facilities or organizations are as follows:

**13.2.1. Operation under the Ownership and Control of the Main Provider:**

The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(a) The business enterprise that constitutes the facility is 100% owned by the provider.

(b) The main provider and the facility seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.

(c) The facility is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the main provider where it is based.

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

As documentation for this requirement, the provider may need to furnish documents such as the articles of incorporation and the bylaws for both the main provider and the facility. The provider also may want to describe who has final approval for administrative

decisions, contracts with outside parties, personnel policies, and medical staff appointments for the facility.

**13.2.2. Administration and Supervision:** The reporting relationship between the facility seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:

(a) The facility is under the direct supervision of the main provider.

Documentation furnished by the provider may include a list of key administrative staff (position/titles only) at the main provider and the facility that reflects a reporting relationship.

(b) The facility is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability.

The facility director responsible for daily operations at the entity:

(i) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and

(ii) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

As documentation, the provider may include a written description of the facility director's reporting requirements and accountability procedures for day to day operations.

(c) The following administrative functions of the facility are integrated with those of the provider where the facility is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are:

(i) Contracted out under the same contract agreement; or

(ii) Handled under different contract agreements, with the contract of the facility being managed by the main provider.

Documentation furnished by the provider may include a list of the various administrative functions (e.g., billing services, laundry, payroll) at the facility that are integrated with the main provider.

**13.2.3. Location:** The facility is located within a 35-mile radius of the campus of the main provider. Note: An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in §412.62(f)(1)(iii) of chapter IV of Title 42, and has fewer than 50 beds is not subject to the per patient visit economic cap. To demonstrate that a facility is located within a 35-mile radius of the main provider, maps or an online service such as Mapquest may be used.

**13.2.4. Obligations of Off-Campus Hospital Outpatient Departments and Hospital-Based Entities:** When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, and the treatment is not required to be provided by the antidumping rules [meaning that the treatment is not for an emergency] in §489.24 of chapter IV of Title 42, the hospital must provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability).

(1) The notice must be one that the beneficiary can read and understand.

(2) If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based.

(3) The hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual services furnished by the hospital.

(4) If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

(5) In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules of §489.24 of chapter IV of Title 42, notice, as described in this paragraph, must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.

For example, information providers may supply as documentation could include a copy of the form given to patients and a copy of their policies regarding distribution of the form. Providers may also supply a copy of their policy on EMTALA compliance. Note that an Advance Beneficiary Notification (ABN) for non-covered services does not meet the requirement of providing written notice of beneficiary liability.

**13.3. Form of Notice Posted in Provider-Based Clinic:** Notice of provider-based status shall be prominently displayed in all waiting rooms located in provider-based clinics.

**13.3.1 Off-Campus Clinic:** A notice substantially similar to the following shall be posted prominently in all waiting rooms located in off-campus, provider-based clinics.

### **WELCOME TO OCH SOUTH**

**OCH South is an outpatient facility owned and operated by Ozarks Community Hospital as an off-campus department of the hospital. Patients treated at OCH South are admitted to the hospital on an outpatient basis.**

**Patients will receive a bill for services provided by the hospital facility (the facility fee) as well as a bill for services provided by the physician (the professional fee). Facility charges will vary depending on the level of service provided by the facility and may include lab, x-ray and ancillary services. The professional fee consists of an examination and treatment charge coded by level of service and may include additional fees for special procedures. Patients may also receive a separate bill for professional services from a third-party radiologist or pathologist.**

**Depending on the type of insurance you have, you may be responsible for a deductible or co-pay amount applicable to either a physician office charge or a hospital outpatient charge.**

**The facility has been approved by Medicare as a provider-based outpatient clinic of the hospital.**

**13.3.2 On-Campus Clinic:** A notice substantially similar to the following shall be posted prominently in all waiting rooms located in on-campus, provider-based clinics.

### **WELCOME TO THE HOSPITAL CLINIC**

**This Clinic is an outpatient service owned and operated by Ozarks Community Hospital as a department of the hospital. Patients treated at the Clinic are admitted to the hospital on an outpatient basis.**

**Patients will receive a bill for services provided by the hospital (the facility fee) as well as a bill for services provided by the physician (the professional fee). Facility charges will vary depending on the level of service provided by the facility and may include lab, x-ray and ancillary services. The professional fee consists of an examination and treatment charge coded by level of service and may include additional fees for special procedures. Patients may also receive a separate bill for professional services from a third-party radiologist or pathologist.**

**Depending on the type of insurance you have, you may be responsible for a deductible or co-pay amount applicable to either a physician office charge or a hospital outpatient charge.**

**13.3.3 Rural Health Clinic:** A notice substantially similar to the following shall be posted prominently in all waiting rooms located in provider-based rural health clinics.

### **WELCOME TO THE OCH LAWRENCE COUNTY CLINIC**

**The OCH Lawrence County Clinic is a rural health clinic owned and operated by Ozarks Community Hospital. The Clinic accepts Medicare, Missouri Medicaid and certain commercial insurances. If you have coverage under a commercial insurance or employer self-funded plan, please inquire for further information prior to service. Depending on the type of insurance you have, you may be responsible for a deductible or co-pay amount applicable to either a physician office charge or a hospital outpatient charge.**

**The Clinic will accept self-pay patients on a case-by-case basis. There is a prompt-pay discount for self-pay patients in accordance with hospital policy. Clinic charges for select office visits and the corresponding prompt-pay discounts are as follows:**

**\*\*\*\* [insert self-pay fee schedule] \*\*\*\***

**13.4. OCH South Emergency Department:** The facility doing business as OCH South obtained provider-based status from CMS by submitting a Medicare Provider-Based Attestation. This off-campus, provider-based facility operates an urgent care clinic. The clinic accepts all walk-in patients regardless of payer status. It is not open 24 hours a day, and it is not licensed by the State of Missouri as an emergency room. The Emergency Medical Treatment and Labor Act (EMTALA) defines a dedicated emergency department (DED) as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

- Licensed under applicable State law as an emergency room/department
- Known to the public (by name, posted signs, advertising, etc) as a place that provides emergency care for medical conditions on an urgent basis without requiring a previously scheduled appointment
- The DED provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

CMS is aware that there are some hospital departments that meet the definition of a DED under EMTALA but do not meet the more restrictive CPT definition of an emergency department. For example, a hospital department that meets the definition of a DED may not be available 24 hours a day, 7 days a week. However, they do provide unscheduled emergency or urgent services for patients who present to their facility. In order to distinguish between these two types of emergency departments, CMS refers to them as the following:

- Type A= Emergency departments that meet the CPT definition
- Type B= Emergency departments that do not meet the CPT definition but provide services under EMTALA.

**13.4.1. Notice of Provider-Based Status and Fees:** The following shall be posted prominently in the waiting area of the South ED:

**WELCOME TO  
OCH SOUTH  
EMERGENCY DEPARTMENT**

**OCH South Emergency Department is an outpatient service owned and operated by Ozarks Community Hospital. It is an off-campus outpatient service of the hospital accepting walk-in patients who require urgent care. Medicare regulations that apply to hospital Emergency Departments (such as EMTALA) apply to this urgent care clinic. Patients treated at OCH South Emergency Department are admitted to the hospital on an outpatient basis.**

**Patients will receive a bill for services provided by the hospital (the facility fee) as well as a bill for services provided by the physician (the professional fee). Facility charges will vary depending on the level of service provided by the facility and may include lab, x-ray and ancillary services. The professional fee consists of an examination and treatment charge coded by level of service and may include additional fees for special procedures. Patients may also receive a separate bill for professional services from a third-party radiologist or pathologist.**

**OCH South Emergency Department is not a physician clinic; neither is it a state licensed ER. It is a hospital urgent care clinic. Accordingly, the hospital codes the facility charge as *urgent care* not as an *emergency*. Depending on the type of insurance you have, you may be responsible for a deductible or co-pay amount applicable to hospital charges.**

**13.5. Provider-Based Clinic as Group Practice:** The physicians employed in the same provider-based clinic should be considered to belong to a group practice. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician. If more than one E&M service is provided on the same day to the same patient by the same physician or more than one physician in the same specialty in the same group, only one E&M service may be reported—unless the E&M services are for unrelated problems. Patients returning to a different physician within the same specialty in a group practice cannot be billed as a new patient visit.