

Provider Based Clinics

Everything you ever wanted to know about Medicare provider-based clinics (and off-campus departments) but were afraid to ask because everyone else assumes you already know it all.

Paul Taylor

Ozarks Community Hospital
healthcare@OCHonline.com
www.OCHonline.com





WARNING MEANT TO FRIGHTEN YOU INTO PAYING ATTENTION!!!

- Independent physicians are migrating to hospital employment at a frenzied pace.
- Many hospitals claim provider-based status for physician practices.
- The government is concerned that a significant number of hospitals fall short of the government-mandated requirements for provider-based status.
- The Office of Inspector General (OIG) lists provider-based non-compliance as one of its top concerns.
- The Obama administration is actively expanding the use of payment recapture audits in federal programs.
- In 2008, the Joint Commission surveyed a Midwest hospital operating a provider-based clinic. During its evaluation, the accrediting organization determined there was a lack of medical-record integration between the hospital and its provider-based clinic. As a result, the commission cited the hospital for deficiencies and required resolution through development and implementation of a corrective action plan.
- POS (*place of service* not *piece of sh—*) coding “errors” that may have gone undetected when there was a different FI processing Part A claims than Part B claims will be easily discovered now that a single FI is processing both.
- It is all fun and games until someone gets hurt: if the hospital operates a physician clinic as a PBC and Medicare determines it does not meet criteria, there will be fines and repayment aplenty.

What is a provider-based clinic (PBC)?

CMS defines “provider” as the hospital. A provider-based clinic means “hospital-based.” In other words, a PBC is essentially a department of the hospital providing outpatient services. Here are some of the requirements for a PBC:



- PBC may be on the hospital’s main campus or within 35 miles of the main campus
- PBC operates under the main provider’s license unless state law mandates separate licensure.
- PBC has ready access to the hospital and other provider-based clinics’ medical records.
- Physicians and staff operating within the clinic are under the same reporting structure as all other hospital departments.
- PBC is incorporated into the hospital’s organizational chart.
- Directors and managers are involved in the same meetings as their peers in other hospital departments.
- PBC professional staff must have hospital privileges.
- PBC support staff receives the same in-service training as the clinical-support staff of the hospital as applicable.
- Hospital policies on infection control, safety, disaster plans, etc. apply at PBC.
- Signage, name badges, business cards, letterhead, logos, billing invoices, voicemail, etc. are identified as that of the hospital.
- PBC appears on the hospital’s trial balance as an identifiable cost center.
- PBC uses the same chargemaster as the hospital.
- PBC Medicare patients are registered as hospital patients.

DEFINITIONS (brought to us by WPS)

Campus: The physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS Regional Office, to be part of the provider's campus.

Department of a provider: A facility or organization or *a physician office* that is either created by, or acquired by, a main provider for the purpose of furnishing healthcare services *of the same type* as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider. The department is not licensed to provide health care services in its own right and is not by itself be qualified to participate in Medicare as a provider. Medicare conditions of participation do not apply to a department as an independent entity.

Free-standing facility: An entity that furnishes healthcare services to Medicare beneficiaries and is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or provider-based entity.

Main provider: A provider that either creates, or acquires ownership of another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity: A provider of healthcare services that is either created by, or acquired by, a main provider for the purpose of furnishing healthcare services *of a different type* from those of the main provider under the name, ownership, and administrative and financial control of the main provider.

Sidebar: note phrases in italics.

Why would anyone want to operate a PBC?

Medicare reimbursement for the basic physician office visit (CPT 99213):

- In a freestanding clinic: \$ 64.14
- In a PBC: \$48.35 (pro fee) + \$63.61 (APC) = \$111.96

A provider-based RHC owned by a hospital with less than 50 beds is exempt from the per-visit reimbursement cap. The difference depends on the allowable costs of the RHC but those costs include costs allocated from the hospital.

Why would anyone *not* want to operate a PBC?

- The reason the government pays more is because it costs more to operate a PBC than a freestanding physician clinic. In return for increased reimbursement, the government gets increased regulatory compliance—including a decreased risk of fraudulent billing.
- Physicians—particularly those who were in an independent practice prior to working in a PBC, perhaps even at the same location—are not always enthusiastic about increased regulatory oversight. It can seem (or even actually prove to be) more trouble than it is worth.
- The increased reimbursement often leads to increased expectations regarding physician compensation. *How does Medicare reimbursement in the PBC fit within the organization's existing physician compensation arrangements?*

Do hospitals have to employ the physicians in the PBC?

- No—as long as the physician follows all the rules and bills everything to governmental payers under POS 22. It works in the operating room (more or less). If the hospital is not billing for the physician there has to be a contract requiring the physician to bill POS 22 **AND** a requirement that the physician will allow the hospital an opportunity to audit the physician's billing records. The hospital is responsible to Medicare even if the physician does the billing.
- If the physician is not employed, it increases the risk that some patients will be treated as “private” patients of the doctor and not admitted to the outpatient service of the hospital. **ALL** patients seen in the PBC must be admitted to the hospital, processed under the hospital medical record system and protected by all the hospital policies mandated by Medicare under the Conditions of Participation.
- **UNLESS**, the hospital and the physician have an agreement to allow specific services be provided to *nongovernmental patients* by accounting separately for the costs associated with those services.
- **REMEMBER**, the PBC is no different than any other department on the cost report. Treating a patient in a PBC without processing the patient as a patient of the hospital would be no different than admitting a patient to a bed in the hospital without including that admission on the cost report.

Does EMTALA apply to the PBC?

Yes.

- EMTALA does apply to off-campus hospital-based departments if it is deemed an outpatient department of the hospital by HCFA. This type of facility may include certain diagnostic facilities, clinics, primary care centers, outpatient therapy facilities, and urgent care facilities. EMTALA will not be imposed on other provider-based entities such as skilled nursing facilities (SNF) or Home Health Agencies (HHA) because they are distinct Medicare providers in their own right.
- If an individual presents to any facility located off of a hospital's main campus and that facility has been determined to be a department of the hospital, then the hospital must provide, within its capabilities, an appropriate emergency medical screening examination and subsequent stabilizing treatment or conduct an appropriate transfer in keeping with EMTALA.

Do physicians working in a PBC qualify for HIT stimulus funding if they meet meaningful use?

I think so.

Congress wanted to include provider-based clinic physicians for HITECH money, but CMS did not (at least, that is my take). Congress clarified its position in HR 4851 (one of the SGR fixes): SEC. 5. EHR CLARIFICATION. (a) Qualification for Clinic-based Physicians-

(1) MEDICARE- Section 1848(o)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w-4(o)(1)(C)(ii)) is amended by striking “setting (whether inpatient or outpatient)” and inserting “inpatient or emergency room setting.”

In other words, physicians working in an inpatient or emergency room setting are excluded, but the deletion of “outpatient” (from the exclusion) would seem to include provider-based clinic physicians.

Who do you call?

Below are the contact names and email addresses for the two main provider-based contacts at WPS.

Name: Darlis Lupton
Title: Provider Based Attestation Coordinator in the Audit Advisement Area
Email: Darlis.Lupton@wpsic.com

Name: Chris Severson
Title: Audit Advisement Supervisor
Email: Chris.Severson@wpsic.com

Provider-Based Attestation Submission Address:
Delivery/Overnight Service:

WPS Medicare
Attn: Chris Severson
Medicare Audit Advisement
3333 Farnam Street, Suite 700
Omaha, NE 68131