

Hospitals and Health Systems: Provider-Based Status: The Rules and Common Issues



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Hospitals focused on growth and development are increasingly interested in providing services off-site of the main campus of the hospital. Moving off-campus can be driven by a number of factors, including: space limitations on the main campus, patient needs, population growth, convenience and other competitive factors. Other hospitals, constrained in existing buildings, are looking to construct and grow on campus. Whether moving off-campus or building on-campus, hospitals must ensure that they satisfy Medicare's provider-based status rules ("Provider-Based Rules") in order to continue to be able to bill for the services provided at the new locations under the hospital's Medicare number. It is important for hospitals to be able to bill under their existing Medicare number because the payment the hospital receives is typically higher than it would be in a clinic or office setting.¹ As a result, the ability to qualify for provider-based status is a critical piece of the economic puzzle for hospitals considering expansion or acquisition of off-campus facilities. The consequence of failing to qualify for provider-based status is that the new facility will be required to have its own Medicare number to seek reimbursement. As stated above, non-provider-based facilities typically experience much lower reimbursement rates than the hospital rate. It is also important to note that the provider-based rules apply to entire facilities, rather than particular services.

A provider-based facility is a facility that is operationally integrated with a main hospital (i.e., it operates under the same name, ownership, and administrative and financial control of the main hospital) such that it is permitted to bill for services under the hospital's provider number. There are a number of requirements that a facility has to satisfy in order to be deemed provider-based, particularly if the facility in question is a joint venture with a non-hospital party or parties. This article outlines the provider-based status rules and provides case study illustrations of the provider-based status rules in operation to highlight common questions that arise in provider-based status situations.

I. Provider-Based Status

A provider-based facility is a provider of health care services either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider.² A provider-based facility comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility.³

The regulations accompanying the Provider-Based Rules set forth the rationale behind granting facilities located on or away from the main provider campus provider-based status:

In order to accommodate the financial integration of the two facilities without creating an administrative burden, we have permitted the subordinate facility to be considered provider-based. The determination of provider-based status allowed the main provider to achieve certain economies of scale. To the extent that overhead costs of the main provider, such as administrative, general, housekeeping, etc., were shared by the subsidiary facility, these costs were allowed to flow to the subordinate facility through the cost allocation process in the cost report. This was considered appropriate because these facilities were also operationally integrated, and the provider-based facility was sharing the overhead costs and revenue producing services controlled by the main provider.⁴

Provider-based status can be sought for an outpatient department of a hospital⁵, remote locations of hospitals⁶ and satellite facilities.⁷ Note that provider-based status determinations under the rules described in this article are not available for the following types of facilities: (A) Ambulatory surgical centers ("ASCs"); (B) Comprehensive outpatient rehabilitation

1 In addition, the provider-based unit or facility can appear on a hospital's cost report and receive an allocation of the hospital's overhead costs. This article does not focus on this aspect since many hospitals are moving away from cost-based payment systems.

2 42 C.F.R. § 413.65(a)(2).

3 *Id.* A provider-based facility may by itself, be qualified to participate in Medicare and the Medicare conditions of participation do apply to a provider-based facility as an independent entity.

4 65 FR 18504 (April 7, 2000).

5 Department of a provider means a facility either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider. A provider-based facility comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. Unlike other types of provider-based entities, a department of a provider may not by itself be qualified to participate in Medicare as a provider and the Medicare conditions of participation do not apply to a department as an independent entity.

6 Remote location of a hospital means a provider of health care services either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider. A provider-based facility comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility. 42 C.F.R. § 413.65(a)(2).

7 Satellite facility is defined in 42 C.F.R. § 412.22(h)(1) and 42 C.F.R. § 412.25(e)(1) as a part of a hospital that 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.

facilities (“CORFs”); (C) Home health agencies (“HHAs”); (D) Skilled nursing facilities (“SNFs”)⁸; (E) Hospices; (F) Inpatient rehabilitation units that are excluded from the inpatient PPS for acute hospital services; (G) Independent diagnostic testing facilities furnishing only services paid under a fee schedule, such as facilities that furnish only screening mammography services⁹, facilities that furnish only clinical diagnostic laboratory tests, or facilities that furnish only some combination of these services; (H) Facilities, other than those operating as parts of critical access hospitals (“CAHs”), furnishing only physical, occupational, or speech therapy to ambulatory patients, for as long as the \$1,500 annual cap on coverage of physical, occupational, or speech therapy¹⁰, remains suspended by the action of subsequent legislation; (I) end-stage renal disease (“ESRD”) facilities¹¹; (J) Departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid (for example, laundry or medical records departments); (K) Ambulances; (L) Rural health clinics (RHCs) affiliated with hospitals having 50 or more beds.¹²

Prior to 2002, in order to obtain provider based status the potential main provider was required to submit an attestation to CMS stating that the facility meets the criteria set forth in the Provider Based Rules (and described below). As of October 1, 2002, providers do not have to submit an attestation to the Centers for Medicare and Medicaid Services (“CMS”); however, if a provider does not submit an attestation and it is later determined that the provider is not eligible for provider-based billing, a recoupment of past payments may be required. Accordingly, the hospital should discuss whether it satisfies the Provider-Based Rules with its fiscal intermediary to adequately assess whether its facility will be deemed provider-based. The hospital should maintain documentation of the basis for its determination that its facility is provider-based. Like the initial attestation process, reporting of any material changes to the relevant provider-based relationships (e.g., change of ownership or entry into a new management agreement) are permissive and not mandatory.¹³ Note, however, that a facility that is located off-campus and which is used as a site to furnish physician services of the kind usually provided in physician offices will be presumed to be a free-standing facility rather than provider-based, unless CMS determines otherwise.¹⁴

A. Requirements Applicable to All Facilities

1. **Licensure.** 42 C.F.R. § 413.65(d)(1) requires that the subordinate facility (“Subordinate Facility”)¹⁵ and the main hospital (“Hospital”) be operated under the same license. There is an exception however, for areas where the state requires the department to have a separate license, or where the law does not permit licensure of the Hospital and the Subordinate Facility under a single license.
2. **Clinical Services.** 42 C.F.R. § 413.65(d)(2) requires that the clinical services of the Subordinate Facility and the Hospital be clinically integrated, as evidenced by the following:
 - (a) The professional staff of the Subordinate Facility has clinical privileges at the Hospital.
 - (b) The Hospital maintains the same monitoring and oversight of the Subordinate Facility as it does for any of its other departments.
 - (c) The medical director of the Subordinate Facility maintains a reporting relationship with the chief medical officer or other similar official of the Hospital that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the Hospital and the chief medical officer or other similar official of the Hospital, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the Hospital.
 - (d) Medical staff committees or other professional committees at the Hospital are responsible for medical activities in the Subordinate Facility, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the Subordinate Facility and the Hospital.
 - (e) Medical records or patients treated in the Subordinate Facility are integrated into a unified retrieval system (or cross reference) of the Hospital.

⁸ Determinations for SNFs are made in accordance with the criteria set forth in 42 C.F.R. § 483.5.

⁹ As defined in section 1861(jj) of Social Security Act. 42 U.S.C. 1395x.

¹⁰ As described in section 1833(g)(2) of the Social Security Act. 42 U.S.C. 1395l.

¹¹ Determinations for ESRD facilities are made in accordance with the criteria set forth in 42 C.F.R. § 413.174.

¹² 42 C.F.R. § 413.65(a)(1)(ii).

¹³ 42 C.F.R. § 413.65(c).

¹⁴ 42 C.F.R. § 413.65(b)(4).

¹⁵ Here and throughout this article, unless specifically noted, Subordinate Facility can mean either the department of the Hospital, the remote location of the Hospital or the satellite facility of the Hospital.

- (f) Inpatient and outpatient services of the Subordinate Facility and the Hospital are integrated, and patients treated at the Subordinate Facility who require further care have full access to all services of the Hospital.
3. **Financial Integration.** 42 C.F.R. § 413.65(d)(3) requires that the financial operations of the Subordinate Facility be fully integrated within the financial system of the Hospital, as evidenced by shared income and expenses between the Hospital and the Subordinate Facility. The costs of the Subordinate Facility must be reported in a cost center of the Hospital and the financial status of the Subordinate Facility must be incorporated and readily identified in the Hospital's trial balance.
 4. **Public Awareness.** 42 C.F.R. § 413.65(d)(4) requires that the Subordinate Facility be held out to the public and other payers as part of the Hospital. Patients must be made aware when they enter the Subordinate Facility that they are entering the Hospital and must be billed accordingly.

B. Obligations Specific to Hospital Outpatient Departments and Hospital-Based Entities

42 C.F.R. § 413.65(g) imposes additional obligations on facilities intending to qualify for provider-based status in relation to a hospital, for example a hospital outpatient department or a hospital-based entity:

1. If the Subordinate Facility is an on-campus hospital department or any off-campus hospital emergency department, it must comply with the anti-dumping rules found at 42 C.F.R. § 489.20(l), (m), (q), and (r) and § 489.24 ("EMTALA"). These regulations generally specify a hospital's responsibility with respect to (i) transferring patients with emergency conditions, (ii) to notifying CMS if it receives an individual who was transferred in violation of the EMTALA regulations, (iii) to posting notices in the emergency department regarding patients' rights, and (iv) to maintaining adequate records of emergency patients, physicians on call, and medical records related to transfers of emergency patients.
2. Physician services furnished in the Subordinate Facility must be billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined under the Medicare Part B rules.
3. The Subordinate Facility must comply with all the terms of the Hospital's provider agreement with Medicare.
4. Physicians who work in the Subordinate Facility are obligated to comply with the non-discrimination provisions in 42 C.F.R. § 489.10(b). These provisions essentially require that physicians agree that they will abide by the Title VI of the Civil Rights Act of 1964¹⁶, Section 504 of the Rehabilitation Act¹⁷, the Age Discrimination Act of 1974¹⁸, or any other requirements of the Office of Civil Rights of the Department of Health and Human Services.
5. The Subordinate Facility must treat all Medicare patients, for billing purposes, as Hospital outpatients. The Subordinate Facility must not treat some Medicare patients as Hospital outpatients and others as physician office patients.
6. In the case of a patient admitted to the Hospital as an inpatient after receiving treatment in the Subordinate Facility, payments for services in the Subordinate Facility are subject to the payment window provisions applicable to prospective payment system hospitals and to hospitals and units excluded from the prospective payment system.¹⁹
7. A number of additional requirements must be satisfied²⁰ when: (i) a Medicare beneficiary is treated in a hospital outpatient department that is not located on the main campus of the Hospital, (ii) the treatment is not required to be provided by the anti-dumping rules set forth in 42 C.F.R. § 489.24 and (iii) the beneficiary will incur a coinsurance liability for an outpatient visit to the Hospital as well as for the physician services.
8. The Subordinate Facility must meet applicable health and safety rules for Medicare-participating hospitals.

¹⁶ Title VI essentially provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity receiving Federal financial assistance

¹⁷ Section 504 of the Rehabilitation Act essentially provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination under any program or activity receiving Federal financial assistance.

¹⁸ The Age Discrimination Act is designed to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance.

¹⁹ The specific rules are set forth at 42 C.F.R. § 412.2(c)(5) and at §413.40(c)(2), respectively.

²⁰ These requirements include the following: (i) the Hospital must provide written notice to the beneficiary, before the delivery of services of (a) the amount of the beneficiary's potential financial liability or (b) an explanation that the beneficiary will incur a coinsurance liability that he or she would not incur if the Subordinate Facility were not provider-based; (ii) the notice must be one that the beneficiary can read and understand; (iii) if the beneficiary is unable to read or understand the notice, the notice must be provided to the beneficiary's authorized representative; and (iv) where the Subordinate Facility provides examination or treatment required by the antidumping rules, notice must be given as soon as possible after the existence of an emergency has been ruled out and the emergency situation stabilized.

C. Obligations Specific to Off-Campus Facilities or Organizations

Due to space limitations on the main campus of the Hospital or because the Hospital desires to reach out to patients in areas located away from the Hospital, hospitals often desire to establish off campus facilities. Pursuant to 42 C.F.R. § 413.65(e) off-campus facilities must meet the requirements outlined in Section I(A) above in addition to the following requirements:

1. Operation and Control. The Subordinate Facility seeking provider-based status must be operated under the ownership and control of the main provider, evidenced by the following: (i) the Subordinate Facility is owned 100% by the Hospital; (ii) the Subordinate Facility and Hospital must have the same governing body; (iii) the Subordinate Facility is operated under the same organizational documents as the Hospital; and (iv) the Hospital has the final responsibility for administrative decisions, contracts with outside parties, personnel actions, personnel policies and medical staff appointments.
2. Administration and Supervision. The reporting relationship between the Subordinate Facility and the Hospital must have the same frequency, intensity and level of accountability that exists in the relationship between the Hospital and one of its existing departments. This can be evidenced by compliance with all of the following: (i) the Subordinate Facility is under the direct supervision of the Hospital; (ii) the Subordinate Facility is operated under the same monitoring and oversight by the Hospital as any other department of the Hospital and is operated just as any other department of the Hospital with regard to supervision and accountability; and (iii) administrative functions of the Subordinate Facility such as, but not limited to, billing services, records, human resources, payroll and employee benefits are integrated with the Hospital.
3. Location. The Subordinate Facility must be located within a 35 mile radius of the campus of the Hospital or if the Subordinate Facility is not located within 35 miles, the facility demonstrates a high level of integration with the main provider by showing it meets all of the other provider-based criteria and demonstrates it serves the same patient population.²¹ The Provider-Based rules also set forth other ways to satisfy the location test for certain types of hospitals (such as children's hospitals, trauma hospitals, rural hospitals, and others). Also, a facility may only qualify for provider-based status if the facility and main provider are located in the same state or, when consistent with the laws of both states, in adjacent states.

D. Requirements Specific to Joint Ventures

Hospitals looking to joint venture with physicians and still take advantage of hospital billing rates will be constrained by the provider-based rules. 42 C.F.R. § 413.65(f) provides that in order for a facility operated as joint venture to receive provider-based status, the Subordinate Facility must meet the following requirements:

1. Be partially owned by at least one provider;
2. Be located on the main campus of the Hospital who is a partial owner;
3. Be provider-based to that Hospital whose campus²² on which the Subordinate Facility is located; and
4. Also meet all of the requirements applicable to all provider-based facilities and organizations discussed below. For example, where a provider has jointly purchased or jointly created a facility under joint venture arrangements with one or more other providers, and the facility is not located on the campus of the provider or the campus of any other provider engaged in the joint venture arrangement, no party to the joint venture arrangement can claim the facility as provider-based.

These requirements prevent a hospital from, for example, joint venturing an ambulatory surgery center off campus with physicians and billing the services under the hospital's billing rate. Although the rules would not necessarily prevent the same hospital from joint venturing with physicians on its own campus (so long as the other requirements are satisfied), this type of arrangement is not usually permissible since if the physician owns part of the entity providing the service and the entity is billing as though it is part of the hospital, then the physician is making a referral that would be prohibited under the Stark Act.²³

21 Specifically, the Hospital must show that during the 12 month period preceding the date on which the Hospital desires provider-based status for its Subordinate Facility, at least 75% of patients served by the Subordinate Facility reside in the same zip code areas as at least 75% of the patients served by the Hospital or at least 75% of the patients served by the Subordinate Facility who required the type of care furnished by the Hospital received that care from the Subordinate Facility. If the Subordinate Facility was not in operation for 12 months, the Subordinate Facility must be located in a zip code area that accounted for at least 75% of the patients served by the Hospital during the last 12 months.

22 The regulations define the term "campus" as "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." 42 C.F.R. § 413.65(a)(2).

23 The referral would be prohibited under the Stark Act because the physician is in essence making a referral for outpatient hospital services which are a designated health service under the Stark Act. 42 C.F.R. 411.351.

II. Common Issues Arising in Connection with Provider-Based Status

A. Joint Ventures and Under Arrangements

Fact Pattern 1:

An acute care hospital (the “Hospital”) and radiologists in the community are joint venture partners in an imaging center (the “Imaging Center”) that is located adjacent to the hospital. The Hospital desires to lease services and equipment from the Imaging Center up to 95% of the time. The Imaging Center owns the hard assets (i.e., equipment and space) used in providing the imaging services but does not itself provide the imaging services. Rather, it operates as a holding company to own the infrastructure itself and then leases the infrastructure to the actual provider of services (here, the hospital). The issue is whether the Imaging Center could be deemed provider-based or whether services can be provided under arrangements for billing purposes.

Rules in Action:

The Imaging Center is partially owned by the Hospital, is located on the main campus of the Hospital and the Imaging Center will be provider-based as to that Hospital. Therefore, the Imaging Center satisfies the specific requirements for provider-based joint ventures and should likely be deemed provider-based (assuming all of the other requirements are satisfied). It is unclear based on the facts whether services could be provided under arrangements. More facts regarding the type of lease entered into would be necessary to determine whether an under arrangements model would be permissible.

In light of the strict requirements for joint ventures, hospitals and physicians have attempted to find alternative methods of utilizing the hospital’s billing number. In these situations, an “under arrangement” model is often discussed and sometimes utilized.

For example, some ambulatory surgery centers that are jointly owned by physicians and a hospital try to take advantage of the “under arrangement” rules by billing for hospital services in the non-hospital setting of the ASC pursuant to an agreement by which the physicians managed the ASC for the hospital. However, as discussed in further detail below, the Centers of Medicare and Medicaid Services (“CMS”) has voiced concern with under arrangements in this context in the 2007 Proposed Physician Fee Schedule.²⁴ Specifically, CMS stated:

We are concerned that the services furnished under arrangements to a hospital are furnished in a less medically-intensive setting than the hospital, but billed at higher outpatient hospital PPS rates, which not only costs the Medicare program more, but also costs Medicare beneficiaries more in the form of higher deductibles and copayments.²⁵

Ultimately, CMS did not make any substantive change to the current regulations but providers are urged to proceed with under arrangements cautiously and to work with legal counsel to structure any under arrangement carefully, as CMS is attuned to the issue and intends to address under arrangements in the future.

The Social Security Act permits providers to bill for services furnished under contract by a non-hospital provider, as services provided “under arrangements.” 42 U.S.C. § 1395x(w). Regulations accompanying the Provider-Based Rules indicate that provider-based status and under arrangements are meant as two separate types of arrangements:

We also proposed to preclude any facility or organization that furnishes all services under arrangements from qualifying as provider-based. We believe the provision of services under arrangement was intended to be allowed only to a limited extent, in situations where cost-effectiveness or clinical considerations, or both, necessitate the provision of services by someone other than the provider’s own staff. The “under arrangement” provision in section 1861(w)(1) of the [Social Security] Act and § 409.3 is not intended to allow a facility merely to act as a billing agent for another.²⁶

In addition, 42 C.F.R. § 413.75(i) specifically states that a facility or organization may not qualify for provider-based status if all patient care services furnished at the facility or organization are furnished under arrangements.

42 C.F.R. § 409.3 states that “arrangements” means arrangements which provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for those services. However, there are no regulations that specifically address the provision of services “under arrangements”. The Medicare Information, Eligibility and Entitlement Manual, Pub. 100-1, Ch. 5, § 10.3, establishes that in order for services provided

²⁴ 72 FR 38187 (July 12, 2007).

²⁵ *Id.*

²⁶ 65 FR 18505.

under arrangements to be covered by Medicare, the provider must exercise professional responsibility over the arranged-for services, including:

- (a) Applying the same quality controls as are applied to services furnished by salaried employees;
- (b) Accepting the patient for treatment in accordance with its admission policies;
- (c) Maintaining a complete and timely clinical record on the patients, which includes diagnoses, medical history, physician's orders, and progress notes relating to all services received;
- (d) Maintaining liaison with the attending physician regarding the progress of the patient and the need for revised orders; and
- (e) Ensuring that the medical necessity of such services is reviewed on a sample basis by the utilization review committee if one is in place, the facility's health professional staff, or an outside utilization review group.

Neither the commentary nor the regulations relating to under arrangements expressly state that the services provided in an under arrangement may be provided in a non-hospital setting. However, it is commonly accepted practice for hospitals to bill for services provided in a non-hospital setting, using the "under arrangements" concept. Therefore, as long as the appropriate procedural requirements are observed, an argument can be made that services may be provided by an outside organization to a hospital patient "under arrangements," and billed to various payors, including Medicare and Medicaid, using the hospital's provider numbers. However, it should also be noted that some third-party payors have challenged "under arrangements," taking the position that the hospital is not entitled to hospital-based reimbursement for services and have converted the bills accordingly. In addition, CMS officials have stated that if a hospital is a partner in a joint venture, its partner cannot provide services for the hospital "under arrangements." CMS has stated that it views such arrangement as if the hospital is receiving services from itself. CMS has not established whether this is the view for all joint venture arrangements or just for joint venture arrangements where the hospital owns more than fifty percent (50%) of the entity.

In certain circumstances, as noted above, CMS does not look favorably on under arrangements structures where those models are viewed as a way of "gaming" the system or artificially increasing the amount of reimbursement received from Medicare or Medicaid (or even commercial payors) above what would normally be expected. As seen in the recent proposed rulemaking actions over the past year, there is a strong possibility that these types of "under arrangements" models may be banned completely in certain situations. When services are provided pursuant to an under arrangements model, these services are generally not eligible for provider-based status. Recently CMS has been more aggressively pursuing these types of arrangements due to perceived abuses in the system where under arrangements models have been used inappropriately as not as originally intended. This is particularly true in the imaging and outpatient surgical services areas. Under the typical under arrangements model, the hospital contracts for an entire line of services and then bills payors for those services under the hospital's provider number at the higher hospital rate. Ultimately, this can cost the Medicare program more, as it must pay the higher rate for reimbursement. Where these are services that could have otherwise been provided without the under arrangements model, CMS views this as abusive and as a circumvention of the intent of federal regulations designed to control fraudulent reimbursement practices. It is advisable to discuss any potential under arrangements with counsel to assess the hospital's comfort level and tolerance for risk.

B. Provider-Based versus Free Standing

Fact Pattern 2:

An acute care hospital operates a vascular access center off site of the main campus. The hospital desires to lease the vascular access center on certain days of the week to a physician group. The issue is whether the vascular access center can be provider-based on some days and free standing on other days.

Rules in Action:

Hospitals that operate provider-based entities may desire to rent the entity to other physicians or providers at times when the Hospital is not utilizing the entity. The question becomes whether an entity can be deemed "provider-based" on certain days and "free standing" on other days. The Provider-Based Rules do not specifically address whether a facility that meets the requirements for provider-based status can seek to operate as provider-based on certain days or at certain times (i.e. at times when the Subordinate Facility leases the facility to the Hospital) and free standing on other days or other times (i.e. when

the Subordinate Facility leases the facility to community physicians) without negatively affecting its provider-based status. However, conversations with CMS have indicated that a facility deemed provider-based may operate as a free standing facility at times when it is not operating as provider-based, so long as the public awareness criteria of the regulations is satisfied. In other words, a patient must be made aware when he or she enters the Subordinate Facility that it is being operated as a Hospital or as the free standing imaging center.

Pursuant to 42 C.F.R. § 413.65(d)(4) which describes what is meant by “public awareness,” patients entering a provider-based facility or organization must be aware that they are entering the main provider and are billed accordingly. There is no further discussion or published CMS guidance as to how an entity or facility can satisfy this requirement. However, in conversations with CMS officials, CMS indicated that the main concept is that it must be absolutely clear to Medicare beneficiaries that they are entering a hospital when they enter the space that is free-standing but provider-based. This can be accomplished by signage indicating the specific days and hours when the space operates as provider-based and when it operates as free-standing. Additionally, CMS suggested that any publications of the main hospital which list the provider-based facility as provider-based should state the specific days and hours that the Subordinate Facility operates as provider-based versus free standing.

C. Use of Space in Provider-Based Facility by Non-Provider-Based Group

Fact Pattern 3:

An acute care hospital (the “Hospital”) owns and operates a building (the “Building”) located approximately 25 miles from the main campus of the hospital. The Building has been designated as a provider-based facility. The Hospital desires to allow a cardiology practice to use office space within the Building during specified times in order to provide professional and ancillary services to its patients. The issue is whether the presence of the cardiology group in an office suite will negatively impact the provider-based status of the Building.

Rules in Action:

Hospitals that operate provider-based entities may desire to rent an office suite within an entity that has been deemed provider-based. As noted above, conversations with CMS have indicated that a facility deemed provider-based may at least theoretically operate as a free standing facility at times when it is not operating as provider-based, so long as the public awareness criteria of the regulations is satisfied. In addition, a space within the building (here, the physician office) may be a free standing space so long as the public is aware that it is not part of the Hospital at that time. As a practical matter, this will be a very difficult requirement to satisfy. For example, a patient could receive treatment at the facility on one day and be billed as if it is a freestanding facility and then the next day receive the same services and be billed as if they were receiving treatment in a hospital provider-based facility. It is likely that CMS would view this type of arrangement skeptically as it would be difficult to avoid confusion as to the status of the facility on any given day. Even if the times and hours were posted clearly, there could be an inherent likelihood of confusion.

D. In State Versus Out of State

Hospitals located on the border of two states that desire to expand may run into an issue of whether it can open a subordinate facility in another state and yet still have that entity deemed provider-based. This is an area where there is not a lot of good guidance. When considering this type of arrangement, it is advisable to work closely with your CMS Field Office and your legal and business advisors to ensure that provider-based status is attainable.

E. Attestation Process

As stated above, a provider is not required to submit an attestation as to its provider-based status for any facility. However, there are significant negative consequences for failing to submit an attestation and later being deemed not a provider-based facility. If a hospital has been billing as if a particular facility were provider-based and CMS later determines that it does not qualify, then the hospital could potentially be liable for repayment of amounts reimbursed by Medicare under the hospital’s provider number for that facility.

Attestations are typically submitted to the local fiscal intermediary which then makes a recommendation to the regional CMS field office who issues a determination. Multiple facilities may be included in the same attestation statement. If a provider chooses to file an attestation for on-campus facilities, supporting documentation is not required to be submitted along with the attestation, unless requested by the fiscal intermediary or CMS. For off-campus facilities, if the provider submits an attestation, it must include supporting documentation.

CMS included a form of attestation in a Program Memorandum issued to fiscal intermediaries on April 18, 2003 (Transmittal A-03-030). This attestation form can be useful to providers who choose to submit an attestation form to CMS. A copy of the form of attestation is attached hereto as [Exhibit A](#). In addition, at least one Regional Field Office of CMS (Region V) has begun to require filing a supplemental attestation by all hospitals that open an off-campus emergency department. This is a requirement specific to off-campus emergency departments and at this point is not a requirement of any other CMS Regional Field Office. Region V has even provided a sample form of attestation which is available upon request to assist in preparing the supplemental attestation. Keep in mind that while the official CMS rules may not require the filing of an attestation generally, in most cases it will likely be advisable. Providers should also verify with their local regional field office to confirm that there are no additional supplemental filing requirements specific to that region.

F. Coordination with Medicare Enrollment

In addition to the optional attestation form a provider may file with their intermediary, a provider will be required to file a Federal Healthcare Provider Enrollment Application on Form CMS-855A under certain circumstances. In the following situations, a provider must also file Form 855A: (i) a facility changes its status to provider-based as a result of a change of ownership; (ii) a facility changes its status to provider-based as a result of an additional location; (iii) the provider-based facility is a rural health clinic and is requesting initial enrollment²⁷; or (iv) the provider-based facility is converting from freestanding to provider-based.²⁸

III. Conclusion

There are plenty of areas where hospitals can run afoul of the current regulations and jeopardize their provider-based status. This article has summarized the traditional guidance on this issue as well as offered a few areas where common problems and challenges arise. Although today certain areas are relatively clear, significant issues do remain. As hospitals look for new and innovative ways to deliver care, the common understandings and conventional wisdom as applied to provider-based status determinations must also evolve to meet the proliferation of off-campus facilities.

²⁷ In the case of a rural health clinic's initial enrollment, the state agency will also conduct a survey and CMS will issue a new provider number.

²⁸ CMS will issue a new provider number when a facility converts from freestanding to provider-based.

Exhibit A

SAMPLE ATTESTATION FORMAT

The following is an example of an acceptable format for an attestation of provider-based compliance.

Please note that provider-based determinations in relation to hospitals are not made for the following facilities: ambulatory surgical centers (ASCs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), skilled nursing facilities (SNFs), hospices, inpatient rehabilitation units that are excluded from the inpatient prospective payment system for acute hospital services, independent diagnostic testing facilities furnishing only services paid under a fee schedule (subject to §413.65(a)(1)(ii)(G)), facilities other than those operating as parts of CAHs that furnish only physical, occupational, or speech therapy to ambulatory patients (subject to § 413.65(a)(1)(ii)(H)), ESRD facilities, departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid (for example, laundry or medical records departments), ambulances.

(Note: As of the date of release of this Program Memorandum, legislation has not been enacted to further extend the moratorium on applying the \$1,500 annual cap on physical therapy, occupational therapy, and speech therapy services of providers and suppliers other than hospitals).

Provider-Based Status Attestation Statement

Main provider's Medicare Provider Number: _____

Main provider's name: _____

Main provider's address: _____

Application Contact name and Phone Number _____

Facility/Organization's name: _____

Facility/Organization's exact address: _____

(Include bldg. no., suite/room no., etc.) _____

Facility/Organization's Medicare Provider Number, if there is one _____

Is the facility/organization part of a multi-campus hospital _____

Is the facility a Federally Qualified Health Center (FQHC)? If so, and if the FQHC meets the criteria at section 413.65(n), it need not attest to its provider-based status. The provider-based rules do not apply to other FQHCs that do not meet the criteria at section 413.65(n), and an attestation should not be submitted.

The facility/organization became provider-based with the main provider on the following date: _____

(Please indicate if this attestation is adding deleting, or changing previous information—if yes, please make certain to include the effective date.)

Indicate whether the facility/organization is "on campus" or "off campus" (per § 413.65(a)(2)) with the main provider:

1. _____ On campus of the main provider (located within 250 yards from the main provider building)

OR

2. _____ Off campus of the main provider (located 250 yards or greater from the main provider building, but subject to § 413.65(e)(3))

I certify that I have carefully read the attached sections of the Federal provider-based regulations, before signing this attestation, and that the facility/organization complies with the following requirements to be provider-based to the main provider (initial ONE selection only):

1. ____ The facility/organization is “on campus” per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(g), other than those in §413.65(g)(7). If the facility/organization is operated as a joint venture, I certify that the requirements under §413.65(f) have been met. I am aware of, and will comply with, the requirement to maintain documentation of the basis for these attestations (for each regulatory requirement) and to make that documentation available to the Centers for Medicare & Medicaid Services (CMS) and to CMS contractors upon request.

OR

2. ____ The facility/organization is “off campus” per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(e) and §413.65(g). If the facility/organization is operated under a management contract/agreement, I certify that the requirements of §413.65(h) have been met. Furthermore, I am submitting along with this attestation to the Centers for Medicare & Medicaid Services (CMS), the documentation showing the basis for these attestations (for each regulatory requirement).

Please complete the following for on campus AND off campus facilities and organizations:

I attest that the facility/organization complies with the following requirements to be provider-based to the main provider (please indicate Yes or No for each requirement):

1. ____ 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, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If the provider and facility/organization are located in a state having a health facilities’ cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers, the commission or agency has not found that the facility/organization is not part of the provider.

2. ____ The clinical services of the facility or organization seeking provider-based status and the main provider are integrated.

2a. ____ Professional staff of the facility or organization have clinical privileges at the main provider.

2b. ____ The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

2c. ____ The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

2d. ____ Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

2e. ____ Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

2f. ____ Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

3. ___ The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.
4. ___ The facility or organization 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 or organization, they are aware that they are entering the main provider and are billed accordingly.
5. ___ In the case of a hospital outpatient department or a hospital-based entity (if the facility is not a hospital outpatient department or a hospital-based entity, please record "NA" for "not applicable" and skip to requirements under number 6), the facility or organization fulfills the obligation of:
- 5a. ___ Hospital outpatient departments located either on or off the campus of the hospital that is the main provider comply with the anti-dumping rules in §§489.20(l), (m), (q), and (r) and §489.24 of chapter IV of Title 42.
- 5b. ___ Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) are billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined under the rules of Part 414 of chapter IV of Title 42.
- 5c. ___ Hospital outpatient departments comply with all the terms of the hospital's provider agreement.
- 5d. ___ Physicians who work in hospital outpatient departments or hospital-based entities comply with the non-discrimination provisions in §489.10(b) of chapter IV of Title 42.
- 5e. ___ Hospital outpatient departments (other than RHCs) treat all Medicare patients, for billing purposes, as hospital outpatients. The departments do not treat some Medicare patients as hospital outpatients and others as physician office patients.
- 5f. ___ 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 chapter IV of Title 42 and at § 413.40(c)(2) of chapter IV of Title 42, respectively. (Note: If the potential main provider is a CAH, enter "NA" for this item).
- 5g. ___ (Note: This requirement only applies to off campus facilities). 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 in §489.24 of chapter IV of Title 42, the hospital provides 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 is on that the beneficiary can read and understand.
- (2)___If the exact type and extent of care needed is not known, the hospital furnishes 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 furnishes an estimate based on typical or average charges for visits to the facility, but states 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 is unable to read a written notice and understand and act on his or her own rights, the notice is 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 at § 489.24 of chapter IV of Title 42, the notice is given as soon as possible after the existence of an emergency condition has been ruled out or the emergency condition has been stabilized.

5h. ____ Hospital outpatient departments meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

For off campus facilities, please complete the following:

In addition to the above requirements (numbers 1-5h), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider as an off campus facility (please indicate Yes or No for each requirement):

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

6a. ____ The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.

6b. ____ The main provider and the facility or organization seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.

6c. ____ The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status is subject to common bylaws and operating decisions of the governing body of the provider where it is based.

6d. ____ 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.

7. ____ The reporting relationship between the facility or organization seeking provider-based status and the main provider has 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:

7a. ____ The facility or organization is under the direct supervision of the main provider.

7b. ____ The facility or organization 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 or organization director or individual responsible for daily operations at the entity--

(1) ____ 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

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

7c. ____ The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization 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 (1) contracted out under the same contract agreement; or (2) handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

8. ____ The facility or organization is located within a 35-mile radius of the campus of the potential main provider, except when the requirements in paragraph 8a of this section are met (please check below in the appropriate location if you qualify for the exemption):

8a. ____ The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under §412.106 of chapter IV of Title 42) greater than 11.75 percent or is described in §412.106(c)(2) of chapter IV of Title 42 implementing section 1886(e)(5)(F)(i)(II) of the Act and is:

(1) ____ Owned or operated by a unit of State or local government;

(2) ____ A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(3) ____ A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

8b. ____ The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the attestation for provider-based status is filed with CMS, and for each subsequent 12-month period:

(1) ____ At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(2) ____ At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(3) ____ If the facility or organization is unable to meet the criteria in (1) or (2) directly above because it was not in operation during all of the 12-month period described paragraph 8b, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph 8b, accounted for at least 75 percent of the patients served by the main provider.

8c. ____ If the facility or organization is attempting to qualify for provider-based status under this section, then the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

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 as determined under 412.105(b) of chapter IV of Title 42, is not subject to the criteria in 8a and 8b above.

9. ____ The facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of 1-8 above, but is operated under management contract, meets all of the following criteria (please respond to 9a - 9d if the facility is operated under a management contract; otherwise record "NA" for "not applicable"):

9a. ____ The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at Part 414 of chapter IV of Title 42. Other than staff that may be paid under such a Medicare fee schedule, the main provider does not utilize the services of "leased" employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

9b. ____ The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph 7c above.

9c. ____ The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph 7b above.

9d. ____ The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

For facilities/organizations operated as joint ventures requesting provider-based determinations: In addition to the above requirements (numbers 1-5h for on campus facilities), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider:

10. ____ The facility or organization being attested to as provider-based is a joint venture that fulfills the following requirements:

10a. ____ The facility is partially owned by at least one provider;

10b. ____ The facility is located on the main campus of a provider who is a partial owner;

10c. ____ The facility is provider-based to that one provider whose campus on which the facility organization is located; and

10d. ____ The facility or organization meets all the requirements applicable to all provider-based facilities and organizations in paragraphs 1-5 of this attestation.

* I certify that the responses in this attestation and information in the documents are accurate, complete, and current as of this date. I acknowledge that the regulations must be continually adhered to. Any material change in the relationship between the facility/organization and the main provider, such as a change of ownership or entry into a new or different management contract, may be reported to CMS. (NOTE: ORIGINAL ink signature must be submitted)

Signed: _____

(Signature of Officer or Administrator or authorized person)

(PRINT Name of signature)

Title : _____

(Title of authorized person acting on behalf of the provider)

(Direct telephone number)

Date : _____

* Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years or both. (18 U.S.C. § 1001).