Requirements for Provider-Based Status Designation

Aug 04 2003

Practice Area: Health Law

REQUIREMENTS FOR ALL SITES

Licensure. Any facility or organization seeking to be provider-based must be operated underthe same license as the main provider, except in areas where:

- The state requires separate license; or
- In states where state law does not permit licensure of the facility or organization and the main provider under a single license with the main provider.

If a state with a rate setting commission finds that a facility or organization is not part of the main provider, the CMS will abide by that decision.

Comments: Joint Commission or other accreditation will not be accepted in lieu of licensure because it may not necessarily reflect an on-site evaluation of the prospective provider based department.

The Center for Medicare and Medicaid Services (CMS) relaxed its proposed requirement that all part of provider operations be under common licensure, in recognition of the fact that many states, like Wisconsin, do not allow licensure of sites that provide only outpatient services as part of a hospital.

Clinical Services. A provider-based facility or organization must share integrated clinical services with the main provider as evidenced by:

- Privileging of the professional staff of the facility or organization at the main provider;
- The main provider's maintenance of the same monitoring and oversight of the facility or organization as of other departments;
- Maintenance of a reporting relationship by the Medical Director of the facility or organization with the Chief Medical Officer (or equivalent) of the main provider that is of the same frequency, intensity, and level of accountability as other departments;
- Requiring the same supervision of the Medical Director of the facility or organization as any other director of the main provider.
- The medical staff committees or other professional committees of 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.
- Medical records for patients in the provider-based facility or organization must be integrated into a unified retrieval system of the main provider.
- Inpatient and outpatient services of the provider-based facility or organization and the main provider are integrated, so that patients treated at the provider-based facility or organization have full access to all services of the main provider and are referred, where appropriate, to the main provider.

Comments: CMS's intent is that a system will be maintained under which both the potential provider-based entity or department of provider and main provider have access to a beneficiary's record, so that practitioners in either location can obtain relevant medical information about care in the other setting.

It is required only that patients have access to services of the main provider and be referred when appropriate. CMS does not intend to restrict a patient's freedom of choice or a practitioner's freedom to refer patients to other locations, where doing so will result in better care for the patient.

Financial Integration. The main provider and the provider-based facility or organization must be fully financially integrated within the main provider's financial system, as evidenced by the sharing of income and expenses. The costs of the provider-based facility or organization must be reported in a cost center of the main provider, and the financial status of the entity is incorporated and readily identified in the main provider's trial balance.

Comments: This requirement will generally be met by a department or division of a single corporate entity subject to a common system of fiscal controls and reporting.

Public Awareness. The main provider and the provider-based facility or organization must be held out to the public as a single entity, so that when patient's enter the provider-based facility or organization, they are aware that they entering the main provider and will be billed accordingly.

Comments: The provider-based site must use the main provider's name in its signage, advertising (radio, TV, internet), forms and general public communications. This requirement does not apply to separately certified provider-based entities (such as a rural health clinic).

Under Arrangement Prohibition. If all services of a facility or organization are furnished under arrangement it cannot be provider-based.

Comments: This prevents comprehensive "outsourcing" of provider-based departments.

Joint Venture Requirements. A joint venture can only be provider-based if it is located on the main campus of a partial owner.

Comments: The joint venture can only be provider-based to the owner on whose campus it is located. It must meet all other requirements.

Additional Hospital Obligations. Hospital departments and hospital based entities are subject to additional "obligations."

ADDITIONAL REQUIREMENTS FOR OFF-CAMPUS SITES

Ownership and Control. The provider-based facility or organization must be under the ownership and control of the main provider as evidenced by the following:

- The facility or organization is 100% owned by the main provider;
- The main provider and the facility or organization have the same governing body;
- The facility or organization is operated under the same organizational documents as the main provider; and
- The main provider has final responsibility for administrative decisions, final approval for outside contracts, final responsibility for personnel policies and final approval for the medical staff appointments in the facility or organization.

Comments: Common control of two separate entities by the same parent organization would not be sufficient to meet this requirement.

Ownership of the business enterprise, not of the buildings or other physical assets of the enterprise, is required.

Relationships that only involve overlapping of ownership, governance, and applicability of bylaws, do not satisfy this requirement.

This prohibits business operations in a joint venture from qualifying as provider-based.

Administration and Supervision. A provider-based facility or organization must have a reporting relationship to the main provider that is characterized by the same frequency, intensity and level of accountability that exists in the relationship between the main provider and one of its departments. As evidence of this relationship, CMS will look at:

- Whether the facility or organization is under the direct supervision of the main provider;
- Whether the facility or organization is operated as any other department with respect to supervision and accountability. The director of the facility or organization or person responsible for daily operations must maintain a reporting relationship with a manager at the main provider that is of the same frequency, intensity, and level of accountability as other departments, and be accountable to the governing body of the main provider, in the same manner as any department head of the provider; and
- Whether the facility is operated under the same monitoring and oversight as any other department of the provider.

The following administrative functions must also be integrated:

- Billing services
- Records
- Human resources
- Payroll
- Employee benefit packages
- Salary structures
- Purchasing services

Comments: The intensity of supervision will be assessed on a case-by-case basis.

Either the same employees or group of employees must handle the administrative functions for both the provider-based facility or organization and the main provider, or the they must be contracted out under the same contract agreement or handled under different contract agreements with the main provider managing the contract for the provider-based facility or organization.

Location. If the provider-based facility and the main provider are located within 35 miles of one another via available roadways, then the geographic proximity requirement is met.

Comments: If the provider-based facility and the main provider are located beyond 35 miles of one another via available roadways, then the provider-based facility must satisfy the difficult "75% test" regarding patients served by both locations. This requirement does not apply to rural health clinics

Management Contract. If an off-campus site is operated under a management contract then:

- The same organization that employs staff of the main provider must employ the staff directly involved in patient care at the site (except for physicians and mid-level practitioners).
- The administrative functions of the site must be integrated per above.
- The main provider must have significant control over the site's operations.
- The contract must be held by the main provider, not a parent corporation.

Comments: Any contracts for a provider-based site must be reviewed for compliance with these requirements.

In addition, the contract must be structured so as not to violate the under arrangement prohibition applicable to all provider-based sites.

Comply with EMTl (Antidumping Requirements). Hospital outpatient departments located either on or off the main hospital's campus must comply with the anti-dumping rules. If any individual comes to any hospital-based entity (including a rural health clinic) that is located on the main hospital's campus, and a request is made for examination or treatment of a medical condition, the hospital must comply with the antidumping rules.

Comments: Applies to hospital outpatient departments but NOT to off-campus provider-based entities that are not hospital departments (i.e., home health agencies).

Main hospital providers must establish certain protocols for handling potential emergency situations at their off-campus departments.

Bill with the Correct Site of Service Indicator. Physician services that are furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site of service indicator, so that applicable reductions to physician and practitioner payments can be applied.

Comments: CMS believes that the main hospital provider has a direct role in ensuring that the physicians who furnish services in its outpatient departments bill with the correct site of service indicator because the main hospital provider controls which physicians practice in the hospital by granting privileges.

Comply with all of the Terms of the Main Hospital's Provider Agreement.

Comments: The provider agreement applies to all provider locations, not just the main campus.

Comply with the Nondiscrimination Provisions Applicable to Physician Services. Physicians who work in hospital outpatient departments or hospital-based entities must comply with Medicare's nondiscrimination provisions.

Comments: This obligation specifies that the civil rights requirements apply to all provider locations.

Uniform Billing. Hospital outpatient departments (other than RHCs) must treat all Medicare patients as hospital outpatients for billing purposes.

Comments: Only applies to provider-based departments, not provider-based entities which may participate separately as providers (i.e., skilled nursing facilities).

Main hospital providers may bill payers other than Medicare in whatever manner is appropriate

Comply with the Payment Window Provisions Applicable for PPS Hospitals or PPS Excluded Hospitals.

Comments: Applies in cases where a patient is admitted to the main hospital provider as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity.

Notice of Coinsurance. Main hospital providers must provide notice to each Medicare beneficiary treated that he or she will be liable for coinsurance for a facility visit as well as for the physician service.

Comments: Applies when a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity that is not located on main provider's campus.

Notice is only required for Medicare beneficiaries, not for all patients.

The notice must be in writing; one which the beneficiary can understand; and must be given to the beneficiary's authorized representative if the beneficiary is unconscious, under great duress or otherwise unable to read and understand the notice.

Comply with all Applicable Medicare Hospital Conditions of Participation.

Comments: This obligation includes compliance with all applicable clinical and life safety code requirements contained in the Conditions of Participation. A violation of any of the Conditions in the hospital outpatient department or hospital-based entity could potentially subject the main hospital provider's Medicare provider agreement to termination.
