

Protecting the Provider-Based Status of Your Satellite Outpatient Clinics

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Hospitals and health systems have increasingly availed themselves of the ability to treat a facility located off of the hospital's campus as a part of the main hospital facility for purposes of billing Medicare (and often private payors) by obtaining "provider-based" status for those off-campus sites. These off-campus provider-based departments may be outpatient surgical centers or may be clinics staffed by physicians providing professional outpatient services. Provider-based status allows the hospital to bill a facility fee for the services under the Hospital Outpatient Prospective Payment System (OPPS) in addition to the applicable professional provider fees. This substantially increases the hospital's reimbursement collections from billing only a professional fee or from billing under the ambulatory surgery center (ASC) fee schedule.

Of course, hospitals incur significant expenses in achieving the level of integration required by the Centers for Medicare & Medicaid Services (CMS) to obtain provider-based status. Nonetheless, hospitals rely on the revenue generated from billing for these off-campus services under OPPS.

Hospitals' financial dependence on provider-based billings and the existence of off-campus provider-based departments are a perennial source of concern for the Medicare Payment Advisory Commission (MedPAC) — CMS' legislative activities arm. MedPAC perennially encourages Congress to revisit off-campus provider-based billing as a means of controlling federal health care spending. This concern is part of a larger Medicare trend of moving toward "site-neutral"

reimbursement — reimbursement for services that remains the same regardless of the setting in which the services are provided. CMS' Regional Offices have also been taking a hard look at attestations for new off-campus provider-based departments and changes in current facilities.

Moratorium on New Provider-Based Clinics Medicare's concerns and activities have culminated in a moratorium on "new" off-campus provider-based departments. This moratorium went into effect on November 2, as part of the 2015 Balanced Budget Act. (On-campus provider-based departments

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are exempt as are off-campus emergency departments.) Off-campus facilities participating in provider-based billing prior to November 2, 2015 are exempt from this moratorium (Existing Locations). Any off-campus departments that begin billing Medicare on or after November 2, 2015 will only be able to bill Medicare under OPPS through December 31, 2016 (New Locations). New Locations will cease provider-based billing on January 1, 2017.

Because of the heavy reliance on the revenue from provider-based billing and because many hospitals are in the process of constructing or setting up new off-campus clinics, the

American Hospital Association and other groups are aggressively lobbying Congress to rescind the moratorium. To date, Congress has not yet acted on this issue.

Potential Future Reduction in Reimbursement to Existing Provider-Based Clinics

Hospitals with Existing Locations should not get too comfortable, however. As of January 1, 2016, CMS is requiring existing off-campus outpatient departments to bill charges using a "-PO" modifier. CMS' intent is to use this as a means to collect data on the cost of patients obtaining these services in a hospital outpatient department as compared to a physician office, ambulatory surgery center, or other freestanding facility. The likely ultimate outcome of this data gathering will be a decision by CMS to reduce reimbursement to make off-campus department payments site-neutral: payments for these sites of services would be in line with reimbursement for physician office, ASC, and other free-standing sites.

What To Do in the Meantime — New Provider-Based Clinics

Hospitals in the process of establishing new off-campus clinics and which were unable to bill under the OPPS for services prior to November 2, 2015 should not necessarily panic yet. Hospital groups are continuing to lobby Congress on the difficulties that the moratorium presents. More immediately, affected hospitals should conduct the necessary financial analysis to quantify what the actual difference would be between billing under the OPPS and billing under the physician and ASC fee schedules (assuming an off-campus site will include an outpatient surgery center). The reimbursement for professional services performed in an off-campus provider-based department is usually significantly less than

the reimbursement for professional services rendered in a physician office. Similarly, the difference between global payment received for services in an off-campus provider-based department and an ASC may be less than expected, especially when factoring in commercial payor reimbursement. (However, hospitals should note that not all services covered under OPSS are necessarily covered under these other systems.)

Bearing in mind that on-campus provider-based billing is unaffected by the moratorium, the financial impact of the

moratorium — while doubtless substantial — may be less significant than initially feared. The hospital can then make a determination regarding converting its off-campus clinic plans to a medical office and outpatient surgery facility.

What to do in the Meantime — Protecting Your Existing Provider-Based Status


Hospitals with off-campus provider-based departments have been experiencing increased scrutiny from CMS, often triggered by a change in location or a

survey. CMS has been focusing its scrutiny on two issues — potential shared space arrangements and compliance with patient notification requirements.


Both of these concerns relate to the requirement, found at 42 C.F.R. 413.65(d) (4), that the off-campus provider-based departments be held out to Medicare patients as a part of the main provider (so that the patients are aware that they will be billed as hospital patients, not physician office patients). Off-campus departments that co-mingle space with non-hospital providers can run afoul of this requirement. Similarly, off-campus clinics that fail to maintain signage clearly indicating that the patient is entering a hospital department — often because the off-campus department is located adjacent to or within another hospital facility — can endanger their provider based status.

Hospitals with Existing Locations should conduct walk-throughs of their space to ensure that patients entering the space will understand, based on the signage, that they are entering a hospital department. The signage should be consistent with the hospital's website, social media accounts, advertising materials, and mailings. These


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hospitals should also take the time to review their location and leasing arrangements for potentially inappropriate shared space arrangements. Each CMS Regional Office has a slightly different interpretation on what constitutes shared space; however, the best practice is to avoid shared suites and other types of co-mingled space.

Expanding an Existing Clinic or Moving to a New Location

CMS has not yet promulgated regulatory guidance on the practical issues presented by the moratorium. CMS has indicated that it will publish proposed regulations sometime in 2016. CMS may opt to publish the proposed regulations in the late spring; however, it may wait until the fall and include them in the proposed 2017 OPSS rules.

In the meantime, hospitals with Existing Locations must carefully examine possible Existing Location expansions and moves. Because off-campus provider-based departments enroll with CMS at a particular location, many providers are viewing an increase in space or an expansion of services in the same suite or at the same address as permissible and not as an action that would endanger the Existing Location's

provider-based status. In other words, the same clinic would continue to bill as it did prior to November 2, 2015. Given the consequences of a loss of provider-based status and the expectation of regulatory guidance becoming available later this year, though, it may be prudent to wait on any contemplated expansions.

Also unclear is how CMS will view a change in location of an Existing Location, i.e., leaving the current location and moving the clinic to a new building or suite. Such a move would not result in the main provider adding an additional outpatient clinic and the hospital's number of provider-based departments would remain the same. The hospital would simply submit a change of information to the Medicare intermediary.

CMS, however, could take the position that a new address indicates a new department. This seems harsh as it would mean clinics could not relocate despite practical reasons for doing so, such as a more convenient location for patients or a more favorable lease rate. But if CMS adopts a strict interpretation of the statutory moratorium, clinic relocations could certainly lead to a loss of provider-based status. Given that CMS has indicated that

it is working on proposed regulations, it would be prudent for hospitals to maintain their Existing Locations in their current locations if at all practicable.



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