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PROVIDER-BASED: THE VISITING SPECIALIST SOLUTION TO CMS'S EVOLVING EXCLUSIVE USE STANDARD

While hospitals have spent much of November 2015 grappling with the fallout of the Budget Act's restriction on off-campus hospital outpatient departments ("HOPD") (see Hall Render's previous articles on the restriction, available here and here), another provider-based issue has quietly gone viral among interested parties, as well as being reported in local news outlets. CMS reportedly revoked the provider-based status of a Montana hospital's provider-based clinic operations because of the hospital's leasing arrangements with visiting specialists. The exact fact pattern is not known to us, but the situation is very common, especially for rural hospitals, including critical access hospitals ("CAHs"), and in some urban settings as well. The purpose of this article is to explain the issues presented in the visiting specialist scenario and identify potential solutions, including one that avoids the provider-based regulatory issues and potential Stark compliance concerns and most closely aligns with the typical operational goals of the parties in these situations.

BACKGROUND

According to local news accounts, the hospital involved had leased space to visiting specialists in two clinic locations for a number of years. One site was apparently in the same building as the main hospital, and the other was across the street. The sites included both provider-based clinic operations staffed by employed physicians and some space used by visiting specialists under part-time leases. The hospital appears to have filed an attestation for provider-based status in 2013. Recently, CMS denied that status and notified the hospital that it will recoup the provider-based differential over the 18-month period since the attestation was filed in the amount of approximately $1.5 million. The hospital has reportedly terminated the leases to the specialists, forcing them to find other venues for providing the services. The reported reasons for CMS denying provider-based status are based on the sharing of space and the public awareness requirement - the public would not be able to differentiate between hospital and freestanding services.

The visiting specialist scenario is very common for many hospitals and CAHs (we will use the term hospital in this article to refer to both). Typically, these leases provide the visiting specialists with use of exam rooms in an outpatient area of the hospital or an attached medical office building that includes hospital departments. The leases typically are periodic, for example, one or two days a week for the specialist to see patients in the hospital's service area. When these arrangements are structured as a lease, the visiting specialist (or their physician practice entity) pays rent to the hospital and bills for the services globally on a CMS Form 1500 using Place of Service ("POS") code 11 (office). In these scenarios, the hospital functions only as a landlord. Often, for operational convenience and efficiency, patient experience and economics, the visiting specialists are adjacent to or in an area also used by the hospital as provider-based clinic space, staffed with hospital employed or contracted physicians.

The CMS decision in the Montana case is likely based on CMS's application of the provider-based requirements and Medicare Conditions of Participation ("CoPs") for hospitals and their departments to be exclusively used for hospital services. This is not a new development but rather an evolving position, and its application by CMS varies across the country. This is not surprising, since guidance is not found in any regulation or sub-regulatory materials and CMS has left the application of the exclusive use/shared space standards to the discretion of the Regional Offices (65 F.R. 18,515, April 7, 2000). In 2011, a similar revocation for an Indiana hospital also went viral. There are many other situations, besides the visiting specialist scenario, across the country where CMS is applying this exclusivity concept.

The exclusivity concept is based on State Operations Manual § 2026 and the CoP requirement that a hospital or a department (a provider-based clinic is a "department") be a "singular unit" dedicated in its entirety to hospital purposes and the treatment of hospital patients. If space within a singular unit (roughly defined as a building or a suite within a multi-tenant building) includes non-hospital operations and patient treatment (such as a part-time freestanding visiting specialist office), then the singular unit does not meet the Medicare CoPs and therefore the provider-based requirements. The application of this principle in the provider-based context is arising from CMS's National Office of Survey and Certification ("S&C"). S&C takes the position that space cannot qualify as hospital space under the CoPs unless it is wholly dedicated to serving hospital patients. If there is freestanding clinic use embedded within a hospital department, then the hospital department does not meet the hospital CoPs and therefore does not comply with the provider-based requirement in 42 C.F.R. § 413.65(g)(3) that a provider-based site comply with all the terms of the hospital's provider agreement and in (g)(8) that a site comply with the applicable

hospital health and safety rules. CMS also tends to raise public awareness issues (42 C.F.R. § 413.65(d)(4)) as an additional provider-based problem in these scenarios.

Another issue presented in the visiting specialist scenario, when the arrangement is with an individual physician or physician-owned professional entity, is compliance with the Stark Law requirements for exclusive use of leased space and the so-called "on-demand" lease rules. Besides the rent meeting a fair market value standard, the Stark rules do not accommodate or allow flexibility in these arrangements. Although the Stark exclusive use rules allow for sharing of registration/waiting areas and hallways (something CMS is not allowing under its interpretation of the provider-based rule), Stark imposes very specific footprint requirements for the leased space and for scheduling. CMS has recently proposed additional flexibility under the Stark rules, but a full discussion of those issues is beyond the scope of this article.

PRACTICAL SOLUTIONS

Move: The most obvious solution - move the visiting specialists to another location that is physically separate from the provider-based space - could result in the services not being convenient for the patients. It also may be less efficient financially, given the need for separate structures or at least separate suites with separate registration, waiting and patient care areas.

Freestanding Clinic: Another option is to convert the entire provider-based clinic site (department) to a freestanding physician practice. Under this option, the hospital would bill for the services provided at that location on a CMS 1500 with POS 11 when the physicians are either employed by the hospital or contract with the hospital for their services and reassign their right to bill to the hospital. Alternatively, the hospital could lease portions of the space to a specialist who would then bill directly for his/her services. If the entire site is freestanding, then the provider-based exclusive use issue is not a concern (although it would still need to be sufficiently segregated in its entirety from other hospital departments). These leases would of course need to comply with Stark and anti-kickback requirements.

PSA: An alternative arrangement for these scenarios is to establish a professional services agreement ("PSA") with the visiting specialists to work in the HOPD space. This is essentially taking the common emergency room coverage agreement and applying it in a different setting on a part-time basis. Instead of a lease, the hospital and physician (or physician group) enter into a PSA that provides the physician access to hospital department space. Implementing the PSA solution obviously requires the agreement of the physicians serving as visiting specialists. The PSA will provide that the hospital bills for the facility component on a UB-04 under the hospital's provider number. Because the hospital is being reimbursed for its facility services by payers, there is no rent charged to the physician. The physician will bill for the professional component on Form 1500 using the appropriate POS code for an outpatient department.

Alternatively, the physicians can reassign their billing rights using CMS Form 855R so the hospital can bill for the professional component under the standard reassignment rules. This is very common in rural emergency departments. If the site is a CAH, then this would allow for Method II billing and payment for the Medicare physician services at 115 percent of the Medicare physician fee schedule. Note that if the professional component billing is reassigned, then the parties must establish a fair market value compensation method to pay the visiting specialists for their services in the HOPD. This could be done on an hourly basis, RVUs or other method not based on the volume or value of referrals that complies with Stark, anti-kickback and potentially tax exemption requirements.

When there is no reassignment of the professional component, the arrangement does not involve any compensation and there is no financial arrangement for purposes of Stark. Nonetheless, we strongly recommend the parties enter into a written agreement to document the relationship, establish the billing responsibilities and document the expected frequency and other terms. The provider-based regulation at 42 C.F.R. §413.65(g)(2) requires a hospital to ensure that physicians working in the HOPD bill with the correct POS. The written PSA is the place to establish and document this requirement.

By structuring the relationship as a PSA, the parties avoid the mixed use issues under the provider-based requirements, which are being raised by CMS in many different contexts. The parties are also able to avoid the Stark exclusive and on-demand restrictions that are often at odds with the operational flexibility the parties generally prefer and desire in these settings. Since the PSA option can be used with a singular unit, it is more economical because there is no need to place visiting specialists in space with a separate waiting area/entrance, registration, patient exam rooms, staff, etc. Finally, and perhaps most importantly, it may often provide the most convenient experience for the patient.

PRACTICAL TAKEAWAYS

Hospitals that provide services in mixed-use locations should anticipate increased scrutiny and enforcement activities by CMS and its application of the exclusive use standard. Accordingly, if space is going to be leased to visiting specialists, or used in any other type of non-hospital function, it should be sufficiently segregated from HOPD space. As CMS stated in 2000, the question regarding sharing of space can only be answered in the context of a specific case. However, given CMS's evolving position and application of the singular unit concept in provider-based settings, hospitals should review these situations for separate entrances, waiting rooms and registration areas. If these arrangements are not feasible, hospitals should be looking at the alternatives of operating sites/departments as either all freestanding or all provider-based, with the use of PSA arrangements instead of leases.

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