HALL RENDER
KILLIAN HEATH & LYMAN

HEALTH LAW NEWS

JULY 01, 2016

PROVIDER-BASED TAKES ANOTHER HIT IN A RECENT OIG REPORT

In June, the Department of Health and Human Services Office of the Inspector General ("OIG") issued a report addressing, in part, the Centers for Medicare & Medicaid Services' ("CMS") oversight of provider-based billing. This report was based on OIG's survey and review of provider-based practices over the last several years. In the report, OIG identified vulnerabilities associated with this billing practice and reaffirmed its recommendation to eliminate the provider-based designation. This report is further evidence of the increased attention and scrutiny by regulators of provider-based facilities.

BACKGROUND

Provider-based facilities are permitted to bill Medicare as a hospital outpatient department and be paid for hospital outpatient services. In some cases, Medicare pays 50 percent more than if the services were performed in a non-provider-based setting. In order to qualify as provider-based, a facility must meet specific requirements set forth in 42 CFR § 413.65. Hospitals may submit a voluntary attestation to CMS certifying that a facility meets the provider-based requirements, and hospitals that voluntarily submit provider-based attestations may receive certain protections against retroactive recoupments in the event of an overpayment and/or denial of provider-based status.

Generally, a provider-based facility may be on campus (within 250 yards of the main provider) or off campus (greater than 250 yards from the main provider but within 35 miles from the main provider). Typically, two claims are submitted for services rendered in these facilities. The hospital will submit a claim on CMS Form 1450 (also known as the UB-04) for the facility fee. The hospital claim is paid pursuant to the Outpatient Prospective Payment System ("OPPS") or based on costs for critical access hospitals. The physician or non-physician practitioner will submit a separate claim on CMS Form 1500 for the professional service rendered with the appropriate place of service ("POS") code to identify the hospital setting. As of January 1, 2016, POS 22 is used to identify services provided in an on-campus provider-based outpatient department and POS 19 is used for services in an off-campus provider-based outpatient department.

In 1999, OIG identified oversight challenges associated with provider-based billing and concluded provider-based status increased costs to Medicare and its beneficiaries with no apparent benefit. Accordingly, OIG recommended that CMS eliminate the provider-based designation. In recent years, the Medicare Payment Advisory Commission ("MedPAC") has asserted a similar position and recommended CMS either close or eliminate the payment gap for certain services. Congress has also enacted laws that effectively eliminate the ability to establish new off-campus departments that will be paid under OPPS.

THE OIG REPORT AND FINDINGS

OIG surveyed a random sample of 333 hospitals to determine the number of provider-based facilities owned by the hospitals. OIG collected documentation from 50 hospitals that reported ownership of off-campus provider-based facilities but had not submitted the voluntary provider-based attestation. OIG analyzed to what extent those 50 hospitals and their off-campus facilities met the provider-based requirements. OIG also collected information from CMS about systems and procedures it uses to oversee provider-based billing and conducted an analysis to determine the benefits of provider-based status.

At the conclusion of its review, OIG reported the following:

- More than 75 percent of the 50 hospitals surveyed that had not submitted a provider-based attestation for their off-campus facilities did not meet at least one of the provider-based requirements.
- Despite CMS's implementation of the new POS codes, vulnerabilities remain. For example, CMS has no independent way to determine the amount of overpayments for on-campus provider-based facilities or hospitals that own multiple off-campus provider-based facilities in one building or campus if the physician claim does not specify the exact location of service.
- CMS reported challenges with obtaining hospital documentation needed to support its attestation reviews.

OIG RECOMMENDATIONS AND CMS'S RESPONSE

Consistent with its 1999 recommendation, OIG called for CMS to eliminate the provider-based designation or, alternatively, equalize payment for the same physician services provided in different settings. Should CMS choose not to implement those recommendations, OIG

made the following recommendations:

1. *Monitor Provider-Based Billing.* OIG recommended that CMS implement systems to monitor provider-based billing and to require that provider-based facilities include unique identification numbers of their claims. CMS partially concurred with this recommendation, stating that the primary monitoring concerns surround off-campus provider-based locations rather than on-campus provider-based facilities.

2. *Require Mandatory Provider-Based Attestations.* OIG recommended that CMS require hospitals to submit provider-based attestations for both on-campus and off-campus facilities. CMS disagreed with this recommendation stating that it has taken several steps to address this issue, including implementing a new facility claim modifier and POS code for services furnished in off-campus provider-based facilities. In addition, the amendments made by Section 603 of the Bipartisan Budget Act of 2015 require certain off-campus provider-based entities be paid under the applicable payment system other than the OPPS beginning on January 1, 2017. CMS believes the foregoing changes limit the vulnerability identified by OIG. Nonetheless, CMS noted it would consider whether additional activities are needed.

3. *Ensure Regional Offices and MACs Conduct Appropriate Attestation Reviews.* OIG recommended that CMS provide further guidance to its regional offices and Medicare Administrative Contractors ("MACs") regarding the documentation necessary to demonstrative compliance with the provider-based requirements, and CMS should ensure regional offices and MACs are applying the requirements consistently and accurately. CMS agreed and indicated that it has worked with the MACs to streamline the attestation review process and has provided training for CMS staff and MACs with respect to the review process.

4. *Take Appropriate Action Against Facilities that Fail to Meet the Requirements.* OIG also recommended, and CMS agreed, that CMS will seek to recover overpayments and take appropriate action against non-compliant provider-based facilities.

PRACTICAL TAKEAWAYS

In light of OIG's report, the recent amendments made by Section 603 of the Bipartisan Budget Act of 2015, MedPAC reports and other initiatives related to limiting provider-based status, both on-campus and off-campus provider-based facilities are likely to continue to face increasing scrutiny. Hospitals should review their provider-based locations to ensure that they meet all the requirements in 42 CFR § 413.65 and determine whether a provider-based attestation should be submitted for those locations.

If you have questions or would like additional information about this topic, please contact:

- Lori Wink at (414) 721-0456 or lwink@hallrender.com;
- Regan Tankersley at (317) 977-1445 or rtankersley@hallrender.com;
- Joseph Krause at (414) 721-0906 or jkrause@hallrender.com;
- Lisa Lucido at (248) 457-7812 or llucido@hallrender.com; or
- Your regular Hall Render attorney.