Current Government Enforcement and Pitfalls in Provider-Based Billing

Briar Andresen (612) 492-7057
Steve Beck (612) 492-7126
Katie Ilten (612) 492-7428

April 13, 2016

Fredrikson & BYRON, P.A.

Overview

- The basics and how we got here
- Sunset rules
- Shared space
- Provider-based versus under arrangements
- Location disputes
- To attest or not to attest?

Provider-based basics

- 42 CFR 413.65
- Hospitals can treat certain facilities/locations as part of the hospital for Medicare payment
  - Integral and subordinate
  - Mostly better reimbursement
    - Facility fee (Medicare)
      - Somewhat lower physician fee schedule payment
    - Patients pay more (two copays)
    - Not all payors recognize provider-based status
  - 340B advantages
  - Different requirements for on-campus vs off-campus

Writing on the wall

- Changes to provider-based reimbursement have been telegraphed for a while
  - MedPAC has been looking for site-neutral payment
  - General unhappiness that E&M services are paid more in an outpatient department than in a physician clinic
  - Same service, higher cost, higher copay
- Proposed changes will save $10B over 10 years
- Since 2014, required submission of data on where services were furnished so that CMS could figure out what services were happening where

2015-16 developments

- 2016 OIG Work Plan, includes review of compliance with provider-based requirements
- As of 2016, claims from off-campus outpatient departments must include a HCPCS modifier (-PO)
  - Physician services must include POS -19 or -22
- Sunset

Sunset provisions

- Section 603
  - Part of the Bipartisan Budget Act of 2015
  - "Treatment of off-campus outpatient departments of a provider"
  - Became law on Nov. 2, 2015
- As of Jan. 1 2017, no payment of facility fees for services in new off-campus departments of providers
  - Does not eliminate provider-based status
  - Doesn't prevent acquisition of departments
  - 42 CFR 413.65 still in effect (603 amends the statute)
  - Applies only to off-campus departments (not on-campus departments, not remote locations of a hospital)

Section 603

- Items and services furnished on or after 1/1/2017 in new off-campus outpatient departments of a provider will not be paid under the OPPS
  - Paid instead under other applicable payment system
  - Removes from definition of “covered OPD services” items and services furnished on or after 1/1/2017 by an off-campus outpatient department of a provider
- Determination of “off campus” becomes a bigger deal
  - Discussed in more detail later on CMS determinations in this area

Section 603

- Defines off-campus outpatient in way that is more expansive under the current regs
  - "Campus" is anything within 250 yards of main buildings, but also anything within 250 yards of remote location of a hospital
- Exceptions for:
  - Items and services provided "by dedicated emergency departments"
  - Departments billing under OPPS prior to 11/2/2015
  - Critical access hospitals and rural health clinics

Section 603

- Hospitals are required (by statute) to provide info to Secretary to allow appropriate implementation of the sunset provision:
  - Codes and modifiers
  - Off-campus departments on Medicare enrollment forms

Section 603: Because I said so….

- No administrative or judicial review under section 1869, section 1878, or otherwise of:
  - Applicable items and services (anything other than items and services in a dedicated ED) and other applicable payment systems (whether it is paid under the physician fee schedule or other payment system).
  - Whether a department of a provider meets the term described in subparagraph (B) (whether it is off-campus or on-campus)
  - Information that hospitals are required to report
    - "may include reporting of information on a hospital claim using a code or modifier and reporting information about off-campus outpatient departments of a provider on the enrollment form"

Still some questions

- Grandfathering doesn't seem to apply to any under-development departments/contractual obligations
  - Possible "fix" in 2017?
    - Would take Congress or CMS to act
    - What would be included?
  - Can a provider add square footage to an off-campus department? Change existing services?
  - Could a provider acquire a location with grandfathered status?
  - New location (or substantial modification) of old site?

More to come, probably

- February AHA letter
  - Upton (Committee on Energy and Commerce)
  - Pitts (Subcommittee on Health)
- Lots of issues with Section 603
- Signaling future action?
- OPPS 2017 (proposed) CMS says they will address some of this—expected in July 2016
  - Providers can send CMS feedback: provider-baseddepartments@cms.hhs.gov

Current enforcement areas

- Shared space
- Under arrangements
- Location disputes

Penalties/problems

- Overpayments
- Violation of COPs
- Federal false claims act?

Shared space

- Medicare is very interested in space sharing between hospital-based and free-standing services. Although it has instructed contractors in writing that there may be situations in which shared space is appropriate, it is now pointing to shared spaces and indicating that provider-based status should be denied.

Shared space – what is the law?

- No statute
- One regulation: 42 C.F.R. 413.65
- Preamble language
- State Operations Manual, CMS Pub. 100-07
- Program Memorandum A-30-030 (April 18, 2003)

Shared space – what is the law?

- The regulation does not address shared space between provider-based and freestanding entities
- The preamble does:
  - "The question regarding sharing of space, however, can be answered only in the context of a specific case, and we expect that such decisions will be made by our regional offices."
  - April 7, 2000 Federal Register

Shared space – can you do it?

- The CMS Central Office and a few Regional Offices have said “no.”

Region V letter

- Freestanding rad department within hospital
- Region V position: a facility that shares space with a freestanding facility does not meet the definition of a “department” of a hospital.
- Rationale:
  - Provider agreement compliance
  - Public awareness

Public Awareness is important

- "[T]he public awareness requirement is not met to the extent the singular component is held out as a freestanding supplier of services, even if it is also held out to the public as a furnisher of hospital services. . . . [S]ome confusion of the two is unavoidable."

Potential harm?

- “By failing to distinguish properly between provider-based and free-standing facilities or organizations, we risk increasing program payments and beneficiary coinsurance with no commensurate benefit to the Medicare program or its beneficiaries . . . .”

Where is the line?

- "CMS may consider a suite in a medical office building to be a singular component for compliance with the hospital CoPs and Medicare-provider based status requirements . . . . However, CMS cannot consider only portions of a singular component when determining if these criteria are met."

Where is the line?

- "There are many elements that are common to shared space arrangements that are likely to cause confusion . . . . These include a shared entrance into the facility, shared registration and waiting areas, passing through a freestanding area to get to the purported hospital area, co-mingling of staff, and signage indicating that a single facility is both hospital space and freestanding space."

Where is the line?

- "Building plans that do not clearly demarcate a purported hospital space as a distinct space is [*sic*.] another possible indicator that the space is not a self-contained component. Rent that is paid to a tenant of a building rather than directly to the building owner or landlord may also be an indication that a space does not itself constitute a singular component."

Region VIII Letter

- Hospital leased office space in hospital building to visiting specialty physicians 2-3 days per month.
- Region VIII conclusion: “A facility that shares space or time with a freestanding facility cannot have provider-based status as a department of a hospital.”
- Rationale:
  - Public awareness
  - Provider agreement compliance

Where is the line?

- "A department of a provider requires sufficient separation from any other facility. Sufficiently separated space is indicated by such features as exclusive entrance, waiting, and registration areas, permanent walls, and a distinct suite designation recognized by the United States Postal Service if the hospital department does not occupy an entire building."

Medical office space

- A main provider hospital may not lease or otherwise obtain use of a portion of a singular component and create a smaller component within that space or sharing time. Certain features, such as shared entryways, interior hallways, bathroom facilities, treatment rooms, waiting rooms, and registration areas are all indications that purported hospital space or time may instead be a part of a larger component. . . .”

Consequences for failure to comply?

- Each letter was an initial determination that found the hospital was overpaid back to the date on which the attestation was submitted.

Attestations

- Shared space for attestation already submitted but not acted upon?
- They are going to say no to the shared space
  - What do you do?
  - Has been taking 1-2 years to get responses

Provider-based vs. under arrangements

- Practical reasons to distinguish:
  - ACA prohibits physician-owned departments or imposes significant restrictions on grandfathered joint ventures or provider-based services.
  - Critical access hospital rules require off-campus provider-based services to meet the 35-mile test.
  - Provider-based rules exclude departments where all services are under arrangements.
  - Stark rules treat provider-based joint ventures differently than under arrangements.

Under Arrangement Requirements

- Under arrangement requirements are far simpler than those for provider-based departments or organizations:
  - Cannot be an entire department;
  - Some services excluded from under arrangement—diagnostic services, physical and occupational therapy are the main under arrangements services;
  - Contract should indicate that payment is in lieu of any separate billing by the entity providing the services under arrangements to the hospital;
  - Hospital must register patient, maintain medical records, apply its quality controls, and include under arrangements service in its utilization review program.

Stark law issues

- If it is a physician joint venture
  - Ownership versus compensation exception (physician ownership of a provider-based department equals prohibited hospital ownership)
  - Definition of “entity” (if the entity provides the entire service, it is included in the Stark definition of “entity”)

Fights about location

- On campus versus off campus
- Lack of definitions
- Inconsistent regulations and preamble

On campus issues

- Rule: a provider-based department must be located on the hospital's "campus."
- "*Campus* means 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."

On-campus issues

- What are the “main buildings”?
- CMS has said to one hospital, “For most hospitals, only a building that houses inpatients can be a main building.” To another hospital, a main building houses inpatients “or significant outpatient services.”

On-campus issues

- "This definition would encompass not only institutions that are located in self-contained, well defined settings, but other locations, such as in central city areas, where there may be a group of buildings that function as a campus but are not strictly contiguous and may even be crossed by public streets. This would also allow the regional offices to determine, on a case by-case basis, what comprises a hospital's campus. We believe allowing regional office discretion to make these determinations will allow us to take a flexible and realistic approach to the many physical configurations that hospitals and other providers can adopt."

On-campus issues

- St. Vincent's case
  - Departmental Appeals Board (Feb. 7, 2008)
  - Docket No. C-07-336
  - Decision No. CR 1734
- CMS denied on-campus based on 250-yard measurement

St. Vincent's

- CMS cited dense urban nature, absence of direct line of sight, existence of businesses, residences along the way
- ALJ: "The determination whether to grant or deny an application for on-campus provider-based status must hinge on the objective to be achieved by the regulation, and the legitimate interests to be protected. . . .

St. Vincent's

- . . . Whether it is added beneficiary financial liability, quality of service, or personal safety, CMS must articulate, in precise terms, the basis for denial of a request for an on-campus provider-based designation. CMS has failed to do so here."
- ALJ remanded case to CMS to articulate a reason for denying the designation of the cancer center as on-campus.

Off-campus issues

- Off-campus provider-based departments must be located within 35 miles of the main campus.
  - As the crow flies?
- Can there be more than one main campus?
  - In the preamble to the supervision rules for diagnostic and therapeutic services provided in a hospital, there is an indication that there can be more than one main campus.
  - What about the merger of two hospitals?

To attest or not to attest?

- That is the question . . . .

Questions?

Briar Andresen
(612) 492-7057
bandresen@fredlaw.com

Steve Beck
(612) 492-7126
sbeck@fredlaw.com

Katie Ilten
(612) 492-7428
kilten@fredlaw.com

58534343