Increased Scrutiny of Provider-Based Status Compliance

A provider-based entity is a provider of health care services that is either created by or acquired by a provider for the purpose of furnishing health care services of a different type from those of the provider, but under the ownership and administrative financial control of the provider.¹ The entity is usually comprised of both the specific physical facility that serves as the site of services of a type for which payment is claimed under the Medicare and Medicaid program, and the personnel and equipment needed to deliver the services at that facility.² Provider-based status is a Medicare reimbursement status for hospitals and clinics that signifies the relationship between the main provider and a provider-based entity.³ A provider-based entity is eligible to bill under the Hospital Outpatient Prospective Payment System instead of the Physician Fee Schedule, which is significant since the OPPS incorporates a reimbursement component for hospital overhead that is greater than the overhead paid for services with a physician’s office.⁴

While providers are encouraged to submit an attestation to CMS stating their belief that the provider-based entity meets the provider-based status requirements⁵ and request an official determination of their provider-based status,⁶ the main provider does not have to wait to gain approval from CMS to bill under the OPPS instead of the Physician Fee Schedule.⁷ However, if CMS determines that the entity does not meet the provider-based status requirements and they had not submitted an attestation for the facility, the provider would be liable for the difference between the total payments CMS made and the total payments CMS estimates should have been made without the provider-based status.⁸ Alternatively, if the provider were to submit an attestation for determination of provider-based status while historically billing as a provider-based entity (without prior official determination of status) and CMS decides the entity does not qualify for provider-based status; the main provider would only be liable for the amount they were overpaid from the point of submitting an attestation and would not be liable for past overpayments by CMS.⁹

According to the Office of Inspector General (OIG), “in 2011, MedPAC expressed concerns about the financial incentives presented by provider-based status.”¹⁰ In June 2013, MedPAC continued to voice its concerns in its report to Congress, in which the organization analyzed the differences between payment types across various settings. MedPAC demonstrated that a 1 minute episode of care for an evaluation and management office visit had a payment difference of $50.88 between a service provided from a freestanding physician practice, billing under the physician fee schedule, and the provider-based entity, billing under the OPPS schedule.¹¹ As a result of the financial incentive concerns related to billing as a provider-based entity, the OIG has made it a Fiscal Year 2015 priority to focus parts of its auditing and review efforts on ensuring that the requirements for compliance with provider-based status are met.¹² Additionally, since CMS does not require regular updates of attestations and their compliance, the OIG reserves the right to audit for compliance at any time.¹³

In the past few weeks, OIG began focusing its compliance auditing efforts on violations regarding shared space contracts with non-provider-based entities. Specifically, the OIG is reviewing the arrangements as they operate in practice, as they were attested to when originally requesting provider-based status, and how this compares to the requirements in the CMS’s regulations.¹⁴ If an entity is out of compliance in any way in regards to the specific requirements of provider-based status the entity will likely lose provider-based status and the OIG will seek recoupment of all applicable wrongful payments.¹⁵ For example, if all of the space and resources in the physically defined area of the department or program are not operating solely for the business of the department or program, the entity’s provider-based status would no longer be in compliance with the regulations.¹⁶

While this strict enforcement should not be perceived as CMS prohibiting all shared spaces under this billing status, organizations employing these arrangements may be well served to ensure that the main provider and provider-based entity’s defined spaces and documentation be updated to accurately represent what is occurring in practice and in compliance on a federal level. This includes ensuring that all of the public details, such as referencing the affiliation on signs and bills, in addition to the clinical operations and billing practices, clearly demonstrate the affiliation between the main provider and the provider-based entity.¹⁷ Non-
compliance under the provider-based status not only puts the entire billing status in jeopardy, but punishment for noncompliance is particularly expensive and organizations should be well aware that the OIG is increasingly looking to this area of fraud and abuse enforcement.

1 “Requirements for a Determination That a Facility or an Organization has Provider-Based Status: Definitions” 42 C.F.R. § 413.65(a)(3) (April 15, 2015).
2 Ibid.
5 42 C.F.R. § 413.65 (April 15, 2015).
6 42 C.F.R. § 413.65(b)(3) (April 15, 2015).
7 42 C.F.R. § 413.65(b)(2) (April 15, 2015).
8 42 C.F.R. § 413.65(j)(1) (April 15, 2015).
14 Ibid.
15 “For Provider-Based Entities, Shared Space is a Big Risk as Auditor Scrutiny Increases” Report on Medicare Compliance, Vol. 23 (May 19, 2014).
16 Youngstrom, April 6, 2015.
17 Youngstrom, April 6, 2015.
Robert James Cimasi, MBA, ASA, FRICS, MCBA, CVA, CM&AA, serves as Chief Executive Officer of HEALTH CAPITAL CONSULTANTS (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Institute of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: “Accountable Care Organizations: Value Metrics and Capital Formation” [2013 - Taylor & Francis, a division of CRC Press], “The Adviser’s Guide to Healthcare” – Vols. I, II & III [2010 – AICPA], and “The U.S. Healthcare Certificate of Need Sourcebook” [2005 - Beard Books]. His most recent book, entitled “Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services” was published by John Wiley & Sons in 2014.

Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious “Award in Business Valuation” conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of HEALTH CAPITAL CONSULTANTS (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the author of the soon-to-be released “Adviser’s Guide to Healthcare – 2nd Edition” (AICPA, 2014), numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: The Accountant’s Business Manual (AICPA); Valuing Professional Practices and Licenses (Aspen Publishers); Valuation Strategies: Business Appraisal Practice; and, NACVA QuickRead. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the Physicians Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

Mr. Zigrang holds a Master of Science in Health Administration (MHA) and a Master of Business Administration (MBA) from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives (ACHE), holds the Certified Senior Appraiser (ASA) designation from the American Society of Appraisers, where he has served as President of the St. Louis Chapter, and is current Chair of the ASA Healthcare Special Interest Group (HSIG).

John R. Chwarzinski, MSF, MAE, is Senior Vice President of HEALTH CAPITAL CONSULTANTS (HCC). Mr. Chwarzinski holds a Master’s Degree in Economics from the University of Missouri – St. Louis, as well as, a Master’s Degree in Finance from the John M. Olin School of Business at Washington University in St. Louis. Mr. Chwarzinski’s areas of expertise include advanced statistical analysis, econometric modeling, and economic and financial analysis.

Jessica L. Bailey, Esq., is the Director of Research of HEALTH CAPITAL CONSULTANTS (HCC), where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions and provides research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services. Ms. Bailey is a member of the Missouri and Illinois Bars and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law, where she served as Fall Managing Editor for the Journal of Health Law and Policy.

Richard W. Hill, III, Esq. is Senior Counsel of HEALTH CAPITAL CONSULTANTS (HCC), where he manages research services necessary to support certified opinions of value related to the Fair Market Value and Commercial Reasonableness of transactions related to healthcare enterprises, assets, and services, and conducts analyses of contractual relationships for subject enterprises. Mr. Hill is a member of the Missouri Bar and holds a J.D., with a concentration in Health Law, from Saint Louis University School of Law.