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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 requirements[5] 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 15 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-

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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)(2) (April 15, 2015).
2 Ibid.
3 "Provider-Based Status, Under Arrangements, Enrollment and Related Medicare Requirements" By Catherine T. Dunlay and Thomas E. Dowdell, American Health Law Association, February 17, 2012, https://www.healthlawyers.org/Events/Programs/Materials/Documents/MM12/papers/LL_dowdell_dunlay.pdf (Accessed 4/17/15) p. 1; 42 C.F.R. § 413.65(a)(2) (April 15, 2015).
4 "Hospital Outpatient Prospective Payment System, ICN 006820" Medicare Learning Network, Centers for Medicare and Medicaid Services, December 2014, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf (Accessed 4/17/15); Dunlay and Dowdell, February 17, 2012, p. 3.
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).
9 "Provider-Based Status on or After October 1, 2002: Transmittal A-03-030" Centers for Medicare & Medicaid Services, Department of Health and Human Services, April 18, 2003, http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A03030.PDF (Accessed 4/17/15), p. 1.
10 "Office of Inspector General Work Plan: Fiscal Year 2013" Office of Inspector General, U.S. Department of Health & Human Services, 2012, https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf (Accessed 4/17/15), p. 2.
11 "Medicare Payment Differences Across Ambulatory Settings" in "Report to Congress: Medicare and the Health Care Delivery System" MedPAC, June 2013, http://www.medpac.gov/documents/reports/jun13_ch02.pdf?sfvrsn=0 (Accessed 4/17/15), p. 32.
12 "Office of Inspector General Work Plan: Fiscal Year 2015" Office of Inspector General, U.S. Department of Health & Human Services, 2014, http://oig.hhs.gov/reports-and-publications/archives/workplan/2015/FY15-Work-Plan.pdf (Accessed 4/17/15), p. 3.
13 "Inspector General Act of 1978" Pub. L. 95-452, § 2, 92 Stat. 1101, 1101 (October 12, 1978); "Provider-Based Rules Trigger 2nd Hospital Settlement; CMS Targets Shared Space" By Nina Youngstrom, Report On Medicare Compliance, Vol. 24 (April 6, 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.

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