Provider-Based Status Update:

How Recent Changes Impact Off-Campus Outpatient Departments’ Compliance, Payment and Transactions

HCCA Annual Compliance Institute
April 18, 2018

David Johnston
614.227.8817
djohnston@bricker.com

Ilah Naudasher
937.681.5124
Ilah.Naudasher@ketteringhealth.org

Claire Turcotte
513.870.6573
cturcotte@bricker.com

Provider-Based Status
What is It and How to Qualify?
### Provider-Based Status: Overview

- Location is treated as part of the main hospital
- CMS will treat a location as part of the hospital, and pay for services under OPPS, only when the hospital maintains control over the quality of care and finances of the location
- Allows the location to qualify for 340B program
- Allows the location to be included in the main provider’s third party payor contracts
- Numerous requirements to qualify at 42 CFR 413.65
- Voluntary attestation to CMS that the location meets requirements
- CMS approval of the location as provider-based eliminates the risk of retrospective recoveries

### Provider-Based Basics

**What does it mean for a location to be provider-based?**

- A Medicare designation that allows hospitals to treat certain departments and facilities located outside of the hospital as part of the hospital for billing purposes
- Services furnished in a location meeting provider based requirements are covered by Medicare as hospital outpatient services
- Exception for non-OPPS services (physical, occupational, and/or speech therapy)
On-Campus vs. Off-Campus

On-campus locations are:

- Buildings or structures within 250 yards from main building
- Measure “as the crow flies”
- CMS Regional Office has discretion to determine on campus on case-by-case basis

Off-campus locations are:

- Not on the main campus or 250 yards from main building or a “remote location” of the hospital
- Provider-based to main provider
- Not a joint venture, not RHC or FQHC

Requirements for On-Campus and Off-Campus Locations

Licensure

- Main provider and location must be licensed under the same license under state law and each outpatient location must be accredited as a hospital outpatient department
  (Note: Ohio does not license hospitals)
Clinical Integration

- All clinical services of main provider (hospital) and location must be integrated by:
  - Professional staff must have privileges at main provider
  - Main provider maintains same monitoring and oversight at location as does for other departments of main provider
  - Location medical director must report to main provider chief medical officer and be supervised as are other medical directors
  - Main provider medical staff and professional committees must be responsible for location activities

Clinical Integration (continued)

- Medical records of location must be integrated into unified retrieval system with main provider so that each site can retrieve records of other

- Inpatient and outpatient services of two locations must be integrated to provide patients of location with access to all services of the main provider
Requirements for On-Campus and Off-Campus Locations

Financial Integration

- Main provider and location’s financial operations must be fully integrated within the financial system of the main provider
- Must have shared income and expenses
- Requires location’s costs and revenue to appear on the main provider’s cost report as a cost center and location is incorporated into main provider’s trial balance

Requirements for On-Campus and Off-Campus Locations

Public Awareness

- Location must be held out to public as part of the main provider
- Patients entering the location and receive services they must be aware they are in a department of the main provider (and not a physician office or other non-main provider site)
- Signage, marketing materials, patient handouts, telephone number and listings, etc. all need to indicate location is part of main provider
Requirements for On-Campus and Off-Campus HOPDs

Hospital outpatient departments (HOPDs) must comply with:

- EMTALA antidumping rules (on-campus and off campus dedicated emergency departments)
- Medicare hospital conditions of participation
- Provider agreement
- Nondiscrimination requirements
- Billing physician services using correct site of service (POS Code 22- On-Campus Hospital Outpatient)
- 3-day payment window
- Advanced beneficiary notice

Additional Requirements for Off-Campus Locations

Ownership and Control

- Location 100% owned by main provider
- Location and main provider share governing body
- Location and main provider operate under same organizational documents
- Main provider retains financial responsibility for administrative decisions (contract approvals, personnel policies, final approval of medical staff appointments)
Additional Requirements for Off-Campus Locations

Administrative and Supervision

• Off-campus location must be under same control as main provider
  – Under direct supervision of main provider
  – Off-campus location director must report to manager at main provider and be accountable to main provider’s governing body
  – Administrative functions (billing, HR, medical records) must be integrated with main provider or contracted under same agreement or under separate agreements maintained by main provider

Distance from Main Provider

• Off-campus location must be within a 35-mile radius of the main provider unless meets alternative test
• Alternative test 75 percent patients in same zip code (i.e., do they serve same population) or DSH hospital
• Measure “as the crow flies” from main provider
• Both main provider and off-campus location must be physically located in the same state or two adjacent states whose laws permit the arrangement to cross state lines, such as using a reciprocal agreement
Billing at Off-Campus PBDs

New modifier and Place of Service (POS) Code for claims for Off-Campus PBDs mandatory as of January 1, 2016 to track off-campus PBDs

- Modifier- PO “Services, procedures, and/or surgeries furnished at off-campus PBDs” for all HCPCS codes for items or services furnished at off-campus PBDs
  - Critical access hospitals (CAHs), remote locations, satellite facilities and emergency departments excluded
- Physician claims in off-campus PBDs use new POS Code 19 - Off Campus Outpatient Department; revised POS Code 22 - On-Campus Outpatient Hospital

Attestation

Compliance with all provider-based requirements is mandatory, but attestation is voluntary

Provider-based status is effective on the earliest date the location and main provider meet the provider-based requirements

To obtain CMS’ determination that a location meets the provider-based requirements, the provider must submit an attestation stating it meets all requirements
Penalties for Non-Compliance

Failure to comply with provider-based requirements exposes the main provider to:

- Overpayment liability
- False Claims Act liability
- Amount of overpayment equals payment differential between provider-based and non-provider-based reimbursement at location (e.g., OPPS versus physician office)

Pros and Cons of Provider-Based Status

Pros

- OPPS reimbursement (if grandfathered or until 1/1/17)
- Included in main provider payor contracts
- 340B drug discount program eligibility
- Main provider DSH and IME payments
- Count residents for GME/IME payments
- Medicare bad debt payments
Pros and Cons of Provider-Based Status

Cons

• Facility fee and physician fee (duplicate co-insurance)
• Physician/patient dissatisfaction
• Regulatory compliance and evolving regulations

On Campus vs. Off Campus

Campus as defined in Provider-Based Rule:

• Physical area immediately adjacent to provider’s main buildings
• Other areas and structures not strictly contiguous to the main buildings but within 250 yards of the main buildings
• Any other areas determined on an individual case basis to be part of the main campus by the CMS Regional Office
Section 603 of the Bipartisan Budget Act of 2015

Background Leading Up to Recent Changes in Provider-Based Rules

- Growth in hospital purchases of physician practices and integration of practices as HOPDs
- Total Medicare payment for service in a HOPD is generally higher than total payment for the same service in a physician office (two claims) and can increase Medicare beneficiary copayments
- Claim “PO” modifier to identify services furnished in OC-HOPD within claims data mandatory 1/1/16, but does not distinguish between multiple OC-HOPDs of same hospital
Bipartisan Budget Act of 2015, Section 603

- Bipartisan Budget Act of 2015 signed into law November 2, 2015
- Section 603 of the Budget Act was applicable to Provider-Based Departments
- As of 1/1/17, no off-campus hospital outpatient department (OC-HOPD) may bill under OPPS unless:
  1. It is a “dedicated emergency department” (DED), or
  2. It is excepted/grandfathered
- After 1/1/17, non-excepted OC-HOPDs will need to bill under another payment system

Dedicated Emergency Departments are NOT Affected

- DED defined by EMTALA definition:
  - State license as an emergency room or emergency department
  - Held out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring an appointment; or
  - Provides at least one-third of all of outpatient visits for the treatment of emergency medical conditions
- **ALL** services at DED (not just emergency services) are exempt from the Budget Act changes
Other Entities/Locations NOT Affected by Budget Act

- On-campus HOPDs
- Provider-based entities (such as rural health centers) — only applies to provider-based departments
- Facilities not billed under OPPS

Statutory Exceptions from Site-Neutral Payments for Provider-Based Locations

- Excepted OC-HOPDs
  - OC-HOPDs that were billing under OPPS for covered outpatient services prior to November 2, 2015 (that have not impermissibly relocated or changed ownership)
  - OC-HOPD that qualifies under the Mid-Build or Cancer Hospital exception
  - HOPDs on the campus or within 250 yards of the main hospital or a remote location of a multi-campus hospital
  - All services furnished at dedicated emergency departments
• How does OC-HOPD get excepted/grandfathered?
  - The 2017 OPPS Final Rule grants excepted status to OC-HOPD if the OC-HOPD furnished any covered OPPS services prior to November 2, 2015, and billed under OPPS in accordance with timely filing limits.

What is a Remote Location of a Hospital?

• Remote location of a hospital means:
  - A facility or organization either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider
  - Comprises both the physical facility that is the site of service and the personnel and equipment used to deliver the service
  - Does not include a “satellite facility”

• Remote locations are considered off-campus of the main hospital, but locations “within the distance” (250 yards) of a remote location are excepted under the Final Rule
Relocation of Excepted OC-HOPDs

- CMS Final Rule prevents excepted OC-HPDs from relocating and remaining excepted
- Concern is the need to prevent hospitals from moving excepted OC-HOPDs to larger facilities to add purchased physician practices
- Must remain at the postal address listed in the hospital's 855 enrollment record
- CMS believes the intent of the Budget Act was to except only OC-HOPDs as they existed prior to November 2, 2015

Final Rule and Relocation of Excepted OC-HOPDs

- Excepted OC-HOPDs can relocate only for natural disasters, seismic building code requirements or significant public health and public safety
- Not for business reasons (e.g., lost lease)
- CMS has issued subregulatory guidance on extraordinary circumstances process; must apply within 30 days of the occurrence
- CMS Regional Offices will approve or deny relocation requests
Grandfathered OC-HOPD

Outpatient Radiology Services
Billed OPPS prior to 11/2/15

New Location in 2017

Outpatient Radiology Services

move

Are the outpatient radiology services furnished at the 2017 new location reimbursed OPPS?

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Expansion of Services at Excepted OC-HOPD

- Budget Act did not address whether an excepted OC-HOPD can expand the number or type of services furnished and remain excepted

- CMS proposed to except only those items or services furnished at the OC-HOPD as of November 1, 2015 (when Budget Act enacted)
  - Any items or services not in same “Clinical Family” would not be able to be billed by excepted OC-HOPD under OPPS as of January 1, 2017
Expansion of Services at Excepted OC-HOPD

- Proposal would have regulated what services are excepted at an excepted OC-HOPD by creating 19 Clinical Families
- But did not limit the *volume* of excepted items or services within a Clinical Family that an excepted OC-HOPD can furnish
- CMS did not finalize the proposal limiting expansion of services into new “Clinical Families”

Expansion of Services at Excepted OC-HOPD

- Under the Final Rule, CMS will pay OPPS rates for all services furnished and billed by excepted OC-HOPDs
- CMS remains concerned about growth at excepted OC-HOPDs
- Concern is with hospitals adding purchased physician practices to excepted OC-HOPDs
- CMS sought feedback about how to limit the type and volume of services and is monitoring service line growth using the “PO” modifier
Hypothetical Expansion of Services – Adding New Service

<table>
<thead>
<tr>
<th>Grandfathered OC-HOPD A</th>
<th>OC-HOPD A 6/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service A</td>
<td>Service A</td>
</tr>
<tr>
<td>Service B</td>
<td>Service B</td>
</tr>
<tr>
<td>Billed OPPS prior to 11/2/15</td>
<td>Add diagnostic radiology</td>
</tr>
<tr>
<td></td>
<td>Add PT/OT</td>
</tr>
</tbody>
</table>

Is diagnostic radiology furnished in OC-HOPD A in 2017 billed OPPS? Does adding PT/OT affect the grandfathered status of OC-HOPD A? Or the OPPS billing of the other services?

Hypothetical Expansion of Services – Adding Space

Existing OC-HOPD
101 Main Street, Suite A

- Outpatient radiology services
- Billed OPPS before 11/2/15

Proposed Addition

- Would radiology services in the Proposed Addition be reimbursed OPPS?
- Would other new services in the Proposed Addition be reimbursed OPPS?
- If the Proposed Addition address is 101 Main Street, Suite A, would services be reimbursed OPPS?
- If the Proposed Addition address is 101 Main Street, Suite B, would services be reimbursed OPPS?
21st Century Cures Act

- Mid-Build Protection
  - February 13, 2017, filing deadline certification and attestation
- Cancer Hospitals
  - 60-day deadline for filing attestation

Payment for Services in OC-HOPDs and Change of Ownership of OC-HOPD, Post-Budget Act
New Payment Structure for OC-HOPDs

- CMS responded to provider community comments in Final Rule and clarified its proposed payment rules
  - CMS believes MPFS is the fee schedule of choice for billing nonexcepted items and services
  - Allows hospitals to continue to bill on institutional claim forms and physicians to bill on physician claim forms – allowing revenue to appear associated with appropriate cost center
  - Rates for these services will continue to evolve through 2017, 2018 and 2019

New Payment Structure for OC-HOPDs

- For services furnished on or after 1/1/2017, hospitals bill using the UB-04 institutional claim form with the new “PN” modifier
  - The modifier serves as a site of service code to denote these claims as receiving the new MPFS payment rate
- For services furnished on or after 1/1/2017, physicians bill claims on a CMS 1500 form at the facility rate
- These rates are designed to appropriately capture service-provision resource costs
New (and Evolving) Payment Rate in OC-HOPDs

• For CY 2017, CMS established a new MPFS rate for “PN” modified institutional claims to reflect the relative resource costs of furnishing MPFS-reimbursed claims in the hospital setting
• New MPFS reimbursement category for CY 2017 is 50% of OPPS rate for same services
  – Based on relative resource information from the old “PO” modifier data and comparison of ASC rates to OPPS rates, but with OPPS-based geographic modifiers

Final Rule: Change of Ownership of OC-HOPDs

• What happens if another hospital or provider only wants to acquire another hospital’s OC-HOPD (not the main hospital)?
  – Lose provider-based status
  – Lose OPPS reimbursement
  – Can get provider-based status back
  – Cannot get OPPS reimbursement back
Final Rule: Change of Ownership of OC-HOPDs

- Must acquire the entire hospital (not just the OC-HOPD) **AND**
- Agree to assignment of the main hospital’s Medicare provider agreement
- If the buyer of the main hospital and OC-HOPD terminates the existing Medicare provider agreement instead of accepting it, OC-HOPD loses excepted status and will not receive OPPS rates

Final Rule: Change of Ownership of OC-HOPDs

- “Provider-based status is defined as the relationship between a facility and a main hospital provider, not an asset that can be transferred from one provider to another.”
- An individual OC-HOPD cannot be transferred from one hospital to another and maintain excepted status
Final Rule: Change of Ownership of OC-HOPDs

- CMS example of how Final Rule applies to hospital combinations:
  - If a hospital owner combines two certified hospitals under one Medicare provider agreement and one CCN, the OC-HOPD loses excepted status unless it was enrolled as a provider-based department of the surviving hospital and billing under OPPS before 11/2/2015

Change of Ownership of OC-HOPDs Examples

- #1 – Hospital A sells excepted OC-HOPD to Hospital B
- #2 – As above, but the OC-HOPD is within 250 yards of Hospital B
- #3 – Hospital A sells excepted OC-HOPD to Hospital B, which has remote location Y. The OC-HOPD is within 250 yards of Y
Change of Ownership of 
OC-HOPDs Examples

• #4 – Hospital A has two campuses, Main Campus and Remote Location. A sells Remote Location to:
  – Entity not yet enrolled in Medicare
  – Hospital B, which is 24 miles from Remote Location
  – Hospital B, which is 40 miles from Remote Location

Change of Ownership of 
OC-HOPDs Examples

• #5 – Hospital A has two campuses, Main Campus and Remote Location, as well as three excepted OC-HOPDs, which are within 250 yards of Remote Location. Hospital A sells Remote Location and three excepted OC-HOPDs to Hospital B. Hospital B is more than 250 yards from Remote Location and each of the three excepted OC-HOPDs.
340B Issues

340B Implications

- Hospitals must qualify and be enrolled as covered entities to purchase 340B-priced drugs
- 340B drugs must be administered in covered entity hospital space that is a reimbursable cost center and identified as such on the cost report, i.e., they need to be provider-based
- Both excepted and non-excepted off-campus PBD sites will qualify for 340B
340B Implications

- Under Final Rule payment policy “services provided at nonexcepted off-campus PBDs will continue to be reported on the hospital cost report”
  - They will have charges associated with services furnished at the location
  - Supports the conception of Section 603 as a payment rule not an elimination of provider-based status

- However, CMS says that HRSA has the final say regarding 340B

340B Reimbursement Changes

- 2018 OPPS Final Rule (issued 11/1/2017, eff. 1/1/2018)
- **Note:** not HRSA rulemaking on 340B program
  - CMS changing the reimbursement for drugs
  - Revenue vs. cost adjustment
  - HRSA has limited regulatory authority on 340B

- “…we are exercising the Secretary’s authority to adjust the applicable payment rate as necessary for separately payable drugs and biologicals (other than drugs on pass-through payment status and vaccines).”
340B Reimbursement Changes

• Previous reimbursement: ASP + 6%
• New reimbursement: ASP − 22.5%
• “…we believe this will better, and more appropriately, reflect the resources and acquisition costs that these hospitals incur. These changes will lower drug costs for Medicare beneficiaries for drugs acquired by hospitals under the 340B program.”

ASP = Average Sales Price

340B Reimbursement Changes

• Previous reimbursement: ASP + 6%
  • (ASP = Average Sales Price)
• New reimbursement: ASP − 22.5%
• Payment changes exclude
  – “Rural” SCHs, children’s hospitals, CAHs and PPS-exempt cancer hospitals
  – Drugs on pass through payments
  – Non-grandfathered provider-based departments
340B Non-grandfathered Sites

- These non-grandfathered sites (i.e., Sec. 603 Site-Neutral Payments)
- Continue to be paid at ASP + 6% (as though in a physician office)
- Change the reimbursement calculus for new PBDs

- “We did not propose to adjust payment for 340B-acquired drugs in non-excepted off-campus PBDs in CY 2018 but may consider adopting such a policy in CY 2019 notice-and-comment rulemaking.”

Space Sharing Issues
Recent CMS Space Sharing Concerns

- July 11 CMS Letter
- May 5, 2015 AHLA webinar
  - David W. Eddiger CMS comments
  - Said space sharing does not comply with Medicare hospital conditions of participation
- November 2015 Montana Hospital revocation of provider-based status due to space sharing problem involving visiting specialists with time share lease in provider-based space (appealed)

Co-Location Principle

- General principle:
  - All certified hospital space, departments, services, and/or locations must be 100% hospital usage 24/7
  - “Hospitals are not permitted to “carve-out” areas as non-hospital space”
  - Cannot be “part time” of the hospital and “part time” another hospital, ASC, physician office, or any other activity
  - Flagged co-location with physician offices as issue
  - CoP and provider-based violations at risk
Co-Location Principle

• Sufficiently separated space is “indicated by”:
  • Exclusive:
    – Entrance
    – Waiting
    – Registration Areas
    – Permanent walls
    – In MOBs, distinct USPS designations

Co-Location Principle

• “indications that a purported hospital space may instead be a part of a larger component”:
  – Shared entryway
  – Interior hallways
  – Bathroom facilities
  – Treatment rooms
  – Waiting rooms and
  – Registration areas
## Hypothetical Space Sharing

### Building A  
**First Floor**

<table>
<thead>
<tr>
<th>Physician Office (not provider-based)</th>
<th>OPSS Services (provider-based)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Can both physician office services and OPSS services be furnished in the same building?</td>
<td></td>
</tr>
<tr>
<td>• Does it matter if they are in same suite? Have the same address?</td>
<td></td>
</tr>
<tr>
<td>• Does it matter if they share a waiting room or registration desk?</td>
<td></td>
</tr>
</tbody>
</table>

## Shared Space Example 1

Hospital opens a provider-based cardiology diagnostic testing center in Suite D of its MOB.

All other Suites have independent physician practices.

Hospital staff register patients for the cardiology diagnostic testing.
Shared Space Example 2

Hospital A buys radiology equipment from Physician B. The equipment is located in the lower level of a building owned by Physician. Main floor divided into ASC and physician office. Enter main door walk straight to registration for physician office. Walk right down a hall to elevator to go to lower level.
Shared Space Example 3

Hospital B buys radiology equipment that is located in Physician Y’s office. The radiology space is separated from the physician office by a door. Hospital and Physician office patients register at the same registration desk but a different sign in sheet. The hospital patient would be escorted back to the radiology area to wait in the radiology area waiting room.

Is this enough separation?
Shared Space Example 4

Hospital acquires a physician practice. The physician owned a CT scanner and it was placed in a separate room inside the physician’s office suite.

The Hospital made the CT scanner “provider-based”.

The physician office staff registered patients for the CT scans.

The Hospital CT scan patients and the physician office patients share a waiting room.
Shared Space Example 5

Multi use building/open floor plan. Physician Practice A has Pod 1 for urgent care services and Pod 3 for private practice services. Pod 2 is Hospital’s B’s imaging and blood draw services.

Pod 1 is on the right, Pod 3 is on the left and Pod 2 is in the back. As patient’s enter they would register for one of the three services.

Each Pod would have its own staff, separate telephone number and separate mailbox area. Mail is delivered to building address and separated internally.

Signage would be outside and inside indicating where the services are located and who the provider is.
Shared Space Example 6

Hospital operates a provider-based clinic in an MOB.
Different specialists come in and see patients during the week.
Employed physicians are billed as provider-based (split billed).
Independent physicians time-share one or two exam rooms (Tues/Thurs) and bill “private office.”
### Auditing Provider Based Compliance

#### Example 6

<table>
<thead>
<tr>
<th>Dr. Office</th>
<th>Exam 2</th>
<th>Exam 3</th>
<th>Dr. Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam 1</td>
<td>Nurses Station</td>
<td>Exam 4</td>
<td>Exam 5</td>
</tr>
<tr>
<td>Registration</td>
<td>Waiting Area</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Auditing Provider Based Compliance

• Auditing of provider based compliance can be a very time intensive project, but also necessary to promote compliance and identify risk areas with the regulations
  – Audit should focus on what you would need to do in a provider based attestation
  – Auditors should have a solid understanding of the regulations, otherwise risk areas could be missed

• Before you start the audit, meet with key leaders and explain the process, needs and risks
  – Be sure leadership understands the importance, as the audit will require significant assistance from a diverse group of people and teams

Auditing Provider Based Compliance

• Conduct site visits of both on and off campus departments as part of the audit process
  – There are more requirements for off campus locations, thus more to audit

• The CMS Provider Based Attestation document should be your guide in the audit
  – Utilize a checklist to keep track of documents, policies, photos, etc.
  – We submitted hundreds of pieces of paper for 1 off campus provider based attestation
Where to Start?

• The first step is to identify all of your hospital outpatient departments that are on and off campus. There are variety of sources you can use to determine these departments, for example:
  – Accreditation documents (HFAP, TJC)
  – Cost report data
  – CMS Enrollment documents (855’s)
  – Locations posted on your hospital’s website
  – Data out of your EMR (departments, cost centers, etc.)

Get Organized!

• Utilizing a checklist we created in Excel, we started by conducting the site visits. The site visits focused on the following areas:
  – Hear how phones are answered
  – Collect forms, letterhead and other documents that are given to patients
    ◦ Consent form
    ◦ Notice of Co-Insurance
    ◦ Face sheets/discharge instructions
  – Internal/External signage (take photos for your audit documents)
    ◦ *Make sure your Marketing team is well versed and understanding of the public awareness requirements-you don’t want the Marketing strategy to put your signage/advertising out of compliance*!
    ◦ Signs on interior/exterior doors
    ◦ Suite signs (make sure separate suite numbers)
    ◦ Doors into treatment areas
Get Organized!

- Verification that space was not shared in the following areas:
  - Waiting room/lobby
  - Employee break room
  - Staff
  - Restrooms
  - Registration/scheduling areas
  - Equipment/supply closets

Sample Checklist

<table>
<thead>
<tr>
<th>Provider Based Compliance Audit Checklist</th>
<th>Department/Provider Name</th>
<th>Date Requested</th>
<th>Documents Required</th>
<th>Action Taken</th>
<th>Completed Audit</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get Organized!</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Now What?

• Start collecting documentation and check off your master list once you obtain the documentation. For example:
  – CMS 855A: make sure the HOPD location has been added to the CMS enrollment forms under the main provider
  – Location verification: print out a map from MapQuest to prove the distance between the main provider and the HOPD
  – Accreditation documents and/or state licensure
  – Lease documents: who owns the building?
  – Update hospital website: HOPD locations must be held out to the public as a department of the main provider
    - For example: Townville Imaging, a Service of ABC Hospital

Documentation for Audit-On/Off Campus

• Clinical Services Integration
  – Key personnel working at HOPD
  – Organizational charts
  – By-laws or other documents regarding clinical privilege requirements and oversight by medical staff committee at main provider
  – Medical Director agreements
  – Proof that inpatient and outpatients services are integrated

• Financial Integration
  – Cost Report
  – Trial balance showing revenues and expenses of the HOPD in relation to the main provider
Documentation for Off-Campus

• Ownership and Control
  – Documentation to prove HOPD is 100% owned by main provider
  – Proof that HOPD has same governing body
  – Key contracts are the same for HOPD and main provider

• Administration and Supervision
  – Documentation to show the same monitoring, oversight, and supervision by hospital leadership of the HOPD as the main provider
  – Proof that administrative functions are all integrated, i.e. payroll billing, HR, purchasing, etc.

Collection of Required Policies

• Policies must be in place regarding the following topics and employees must be aware of the policy:
  – EMTALA
  – Correct Site of Service (place of service)
  – Non-discrimination provisions
  – 3 day payment window
  – Co-Insurance Notice
  – Unified medical record system
Finalize Audit!

- Complete attestation document as if you are attesting to your MAC
- Keep all required documents together in a central repository in case you are audited by an external agency
- Make all necessary changes promptly!

Additional Audit Check Points

- Make sure PO and PN modifier are being used correctly
- Establish an entity wide process to follow when departments move, new one’s get added, etc. to be sure provider based rules are followed
- Make sure all forms, marketing material, website, signage, etc. is consistent and compliant
Questions?

David Johnston  
Bricker & Eckler LLP  
100 South Third St.  
Columbus, OH 43215  
614.227.8817  
djohnston@bricker.com

Ilah Naudasher  
Kettering Health Network  
1 Prestige Pl., Ste. 400  
Miamisburg, OH 45342  
937.681.5124  
Ilah.Naudasher@ketteringhealth.org

Claire Turcotte  
Bricker & Eckler LLP  
201 E. Fifth St., Ste. 1110  
Cincinnati, OH 45202  
513.870.6573  
ceturcotte@bricker.com