
CMS clarifies that approval of provider-based status is not required for any entity. Rather, if a provider chooses to obtain a provider-based determination, such determination will essentially protect the provider against retroactive liability. That is, if a provider seeks provider-based status and receives a determination, it will be protected from liability as of that date in the event of a subsequent decision by CMS that the site is not provider-based. Such policy assumes accurate representation by the provider to CMS.

An on-site provider-based facility is defined as a facility within 250 yards of the main hospital buildings. On-site facilities need only comply with the following requirements:

1. common licensure (if applicable)
2. clinical service integration
3. financial integration
4. public awareness
5. “obligations of hospital outpatient departments”

This last category includes compliance with anti-dumping rules, correct site-of-service billing for physicians, the hospital’s provider agreement, nondiscrimination provisions, treatment of Medicare patients as hospital outpatients for billing purposes, the Medicare payment window, and applicable hospital health and safety rules. Thus, on-site provider-based facilities do not have to meet other criteria previously in the regulations which now apply only to off-site provider-based facilities.

Significantly, CMS has removed the management contract requirements for on-site provider-based facilities. Providers may now enter into management contracts for on-site facilities without having to employ the personnel providing services under the management contract.

In addition to the criteria listed above, off-site provider-based facilities must meet other criteria, including:

1. operation under the ownership and control of the main provider;
2. integrated administration and supervision; and
3. location within a 35-mile radius of the hospital campus (or the “75% geographic overlap rule”).

Off-site provider-based facilities must also provide prior written notice to the beneficiary of the amount of the beneficiary’s potential coinsurance liability, although such requirement is not technically listed in the additional criteria section for off-site facilities.

Instead of submitting an application for provider-based status, CMS now provides for an attestation process for both on-site and off-site provider-based facilities. Providers may submit an attestation without any documentation for on-site provider-based facilities. CMS has proposed permitting enrollment of physical and occupational therapists as Part B suppliers even if they are employed by physician groups. The final rule should be published by November 1, 2002.

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Watch For It!

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based entities. However, for off-site facilities, providers must submit documentation in addition to an attestation. Some CMS Regional Offices may interpret this documentation requirement to mean that submission of the prior provider-based application is required. In the preamble, CMS clarifies that there will be an attestation form, but it will take some time before such a form is available. In the meantime, providers may simply submit an attestation of the criteria.

For the first time, CMS allows provider-based facilities to be owned by joint ventures. That is, joint ventures can qualify for provider-based status if the provider is one of the owners and the facility is located on the main campus. This liberalization of the provider-based rules will allow more innovative arrangements, such as financing by manufacturers. Of course, in the case of physician ownership of hospital-based joint ventures, the Medicare and Medicaid fraud and abuse laws and the Stark Law will need to be reviewed.

While the new regulations have helped clarify a number of the ambiguities and inconsistencies contained in the prior rules, there are still issues that remain. One is the policy for multi-campus providers. Under the current rules, when a provider has several campuses, it must designate one campus as the “main” campus and the subordinate campus or campuses must meet the provider-based criteria relative to the main campus. This requirement does not make sense for the many hospitals that have several campuses of equal size and administrative authority. It also seems unnecessary given the fact that multi-campus hospitals have been certified as single provider’s under the provider-based rules as incorporated by the State Operations Manual. Another policy that is still unclear is the distinction between the provision of services as provider-based or under arrangement. Under-arrangement services are authorized by the Medicare statute and allow providers to furnish services indirectly through outside vendors. Both types of services receive the same reimbursement under the outpatient APCs. Under-arrangement contracts do not have to meet the provider-based criteria, although a recent regulatory change could be interpreted as requiring off-site under-arrangement services to meet the provider-based rules. See 42 C.F.R. § 410.27.

CMS also extended the statutory grandfather clause for provider-based facilities in existence on October 1, 2000. Such facilities will be protected from retroactive recoupment of payment until their cost reporting period beginning after July 1, 2003. Providers that have submitted applications for provider-based status prior to October 1, 2002 will be protected from any retroactive recoupment until the provider-based determination is made.

**PPS for Long Term Care Hospitals**

In the August 30, 2002 Federal Register, CMS issued the final rule for the Long Term Care Hospitals (“LTCH”) Prospective Payment System (“PPS”) effective for cost reporting periods beginning on or after October 1, 2002. Interestingly, CMS indicated that it will not have the necessary changes in place for claims processing and payment under the new PPS until after January 1, 2003. The facilities likely to be impacted by this are those with fiscal year endings before the new year. The new LTCH PPS rule is budget neutral.

The LTCH PPS uses the acute care inpatient DRGs weighted to account for the difference in resource use by LTCH patients.

Significantly, the LTCH PPS rule would “clarify” that the 25-day average length of stay (“ALOS”) applies only to Medicare patients. This is a change from existing policy, which included patients of all payers. Presumably as a concession, CMS policy now allows the inclusion of Medicare noncovered days in the ALOS calculation. An issue that arises is how the intermediary will track Medicare noncovered days.

LTCHs are defined in the Medicare statute as hospitals with an average inpatient length of stay greater than 25 days. The PPS uses information from LTCH patient records to classify patients into distinct LTC-DRGs based on clinical characteristics and expected resource needs. Patient cases will be classified into one of approximately 500 DRGs for payment based on the principal diagnosis, up to 8 additional diagnoses, up to 6 procedures, age, sex and discharge status. In addition, the final rule provides a 60-day window within which an LTCH may request review of an LTC-DRG assignment.

The final rule provides for a transition period from cost-based reimbursement to a PPS made up of a blended rate, although LTCHs have the option of electing payment at 100% PPS at the start of any cost reporting period during the transition. Historically, because payments received by LTCHs under TEFRA were not tied to ICD-9-CM coding, there may not have been as much attention to complete and accurate ICD-9-CM code assignments as there will now be. Accurate reporting at LTCHs will be necessary to encourage or correct payment levels in future updates commensurate with costs incurred by the facility.
Retroactive Payments Available for Diabetes Self Management Services

Medicare currently covers Diabetes Self Management Training (“DSMT”) services furnished to hospital outpatients. Since February 27, 2001, the inception of the benefit, fiscal intermediaries (“FI”) reimbursed hospitals for DSMT on a reasonable cost basis. However, as of October 1, 2002, the reimbursement methodology will no longer be based on cost, but rather on the comprehensive outpatient rehabilitation facility (“CORF”) Supplementary Fee Schedule. (Program Memorandum A-02-032 (“PM”)). At the hospital’s request, this reimbursement change may be applied retroactively to claims for dates of service occurring on or after February 27, 2001.

The American Association of Diabetes Educators has reported that DSMT programs were receiving $1-$10 per hour for training. Under the new reimbursement structure the national average for DSMT reimbursement is $30.04 per 30-minute increment when billing the GO108 (individual) code and $17.74 per 30-minute increment when billing the GO109 (group) code.

Through our informal discussions with CMS, we learned that the retroactive payment was taking place because hospitals had been underpaid for DSMT services. Moreover, CMS expects most hospitals to have increased reimbursement under the new payment structure. However, hospitals must review their historical reimbursement for DSMT services to determine if this is the case with respect to their facilities. If there is an opportunity to gain additional reimbursement, contact your FI to determine its resubmission process and resubmit the claims. The hospital will not be required to return the original reimbursement in order to receive the reimbursement amount under the CORF Supplementary Fee Schedule. Rather, FIs should simply pay hospitals the difference between the old cost-based and new fee-schedule-based formulae.

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