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Complete Healthcare Compliance Manual 2024 Provider-Based Rules and Regulations

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What Are Provider-Based Rules and Regulations?

Hospitals and other healthcare providers often are faced with the decision of whether to treat locations or sites outside the four walls of their main provider location as part of the main provider or as freestanding entities—in other words, the decision to make them provider-based to the main provider. "Provider-based" is a Medicare payment designation established by the Social Security Act that allows facilities owned by and integrated with a healthcare provider (usually a hospital) to bill Medicare as a department of that healthcare provider, often historically resulting in these facilities receiving higher payments than they would as freestanding facilities.[3] Hospitals are the type of healthcare provider that most commonly elect to treat such locations or sites as provider-based, but other types of healthcare providers (e.g., skilled nursing facilities, federally qualified health centers, and rural health clinics) can also have locations that are considered provider-based to the main provider. This article focuses primarily on hospitals and their provider-based locations, since that is the most common use of provider-based status and that is where the Centers for Medicare & Medicaid Services (CMS) recent rulemaking efforts have focused.

Being designated as provider-based allows hospitals to treat certain departments and facilities located outside of the hospital as part of the hospital for Medicare—and, depending on state law, sometimes Medicaid and commercial payer—billing and payment purposes. Services furnished in a location meeting the applicable provider-based requirements are considered by Medicare to be hospital outpatient services, but they may not be paid under the Medicare Outpatient Prospective Payment System (OPPS), depending on the circumstances, as discussed later in this article.

A number of possible reasons exist for making a location outside the hospital provider-based to the hospital. It could be to address capacity and space issues within the hospital itself; improve patient convenience and access to hospital-level care in locations other than where the main hospital is located; for quality purposes; to permit the location to participate in hospital contracts (including payer contracts); and/or to permit the provider-based location to participate in the 340B drug discount program (as the provider-based location of the hospital will be included on the hospital's cost report and may qualify to be a child site for 340B drug discount program purposes).

When a location has provider-based status, the hospital can bill Medicare for the services provided in the location just as it would for other hospital services. Under the Medicare system, that means the hospital bills for its facility fee or technical fee, and the physician separately bills for the professional services. (The same is not true for many commercial payers that do not allow a "split bill." Payer rules will need to be consulted to determine how to bill each payer in this situation.) This ability to charge the facility fee is where the primary financial benefit of provider-based status is for hospitals. If the same services furnished in a hospital-based clinic were instead provided in a physician office, no facility fee could be billed; only the physician's professional fee, using the place of service (POS) code 11 to reflect physician office, could be billed to Medicare. The physician's reimbursement under the Medicare Physician Fee Schedule (MPFS) is higher when POS code 11 is used than when services are

provided in a hospital facility location and billed using one of the applicable hospital POS codes.[4] This is because when the physician furnishes services in a hospital facility location, Medicare assumes that the physician is not incurring the same amount of overhead that the physician incurs for services provided in the physician's private office. The hospital's overhead and other expenses are reimbursed through the facility fee or technical fee that the hospital bills to Medicare for the visit. Taken together, the physician's professional fee, combined with the hospital's facility fee, usually results in a higher combined reimbursement for the service than Medicare would have paid if the services were provided in a nonhospital setting. In addition, the Medicare beneficiary who receives services from a location that is provider-based to the hospital will often have two cost-sharing liabilities —one for the hospital bill and another for the physician bill.

Historically, there has been a payment differential, known as the site differential, for services provided in hospital outpatient departments or clinics versus freestanding clinics and physician offices, but many of those payment differentials have been eliminated in recent years, especially for newer locations. Even with many of the payment differentials eliminated, there are still other advantages to being provider-based to a hospital that may make it advantageous to pursue provider-based status. Yet with those advantages there are also certain responsibilities and compliance risks.

Risk Area Governance

The Medicare regulation setting forth the requirements for provider-based status is 42 C.F.R. § 413.65 —"Requirements for a determination that a facility or an organization has provider-based status" (referred to herein as the "provider-based regulation").[5] The provider-based regulation is divided into several sections, some of which have general applicability for all provider-based departments and locations, and others whose applicability only apply to hospitals or otherwise depend on particular facts and circumstances.

In addition to the specific requirements of the provider-based regulation, embedded within it are additional legal requirements with which provider-based locations of hospitals must also comply, since they are considered part of the hospital. These include the Emergency Medical Treatment and Labor Act (EMTALA) (42 U.S.C. § 1395dd) and the Medicare Conditions of Participation (COPs) for hospitals (42 C.F.R. § 482).[6] [7]

Provider-Based Regulation Definitions

The provider-based regulation applies to all facilities for which provider-based status is sought. The provider-based regulation includes a number of definitions for terms used throughout the regulation. They include:[8]

- **Provider-based status**: The "relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility."
- **Freestanding facility**: An "entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity."
- **Main provider**: The "provider that either creates, or acquires ownership of, another entity to deliver… health care services under its name, ownership, and financial and administrative control."
- **Provider-based entity**: A provider of healthcare services "that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a *different* type from those of the main provider under the ownership and administrative and financial control of the main provider." (emphasis added)

- **Department of a provider**: A "facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the *same* type as those furnished by the main provider." (emphasis added)
- **Remote location of a hospital**: A "facility or an organization that is 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." It comprises both the physical facility that is the site of service and the personnel and equipment used to deliver the service and does not include a "satellite facility."

Provider-based entities, departments of a provider, and remote locations of a hospital include the physical facility that serves as the site of services of a type that could be claimed under the Medicare or Medicaid program *and* the personnel and equipment needed to deliver the services at that facility.

Provider-Based Determinations

The provider-based regulation makes clear that a facility or organization is not entitled to be treated as provider-based just because it believes it is provider-based. Such a facility or organization must meet all of the applicable regulatory requirements in order to be appropriately treated as provider-based. Under current CMS policy, healthcare providers may, but are not required to, seek a determination from CMS that their facilities meet the requirements of the provider-based regulation.

However, CMS will not make determinations of provider-based status for payment purposes for the following types of facilities, since such determinations would not affect either Medicare payment or Medicare beneficiary liability or scope of benefits:[9]

- Ambulatory surgery centers
- Comprehensive outpatient rehabilitation facilities
- Home health agencies
- Skilled nursing facilities (determinations are made in accordance with 42 C.F.R. § 483.5 instead)
- Hospices
- Inpatient rehabilitation units that are excluded from the inpatient prospective payment system for acute hospital services
- Independent diagnostic testing facilities furnishing only services paid under a fee schedule, facilities that furnish only clinical diagnostic tests (excluding clinical diagnostic laboratories that are parts of critical access hospitals (CAHs)), and facilities that furnish only some combination of these services
- Facilities (except those operating as part of CAHs) furnishing only physician, occupational, or speech therapy to ambulatory patients during any period when the annual payment cap for coverage of such services is suspended by legislation (see Section 1833(g)(2) of the Social Security Act for more information)
- End-stage renal disease facilities (determinations are made in accordance with 42 C.F.R. § 413.174)
- Departments of providers that perform necessary functions but do not provide services of a type for which separate payment could be claimed under Medicare or Medicaid (examples include laundry and medical records department)

- Ambulances
- Rural health clinics affiliated with hospitals with 50 or more beds

Healthcare providers that seek a determination of provider-based status must submit an attestation to CMS that documents compliance with the requirements of the provider-based regulation. The applicable requirements vary depending on whether the facility is on the campus of the main provider or not and whether the main provider is a hospital. Attestations for off-campus facilities must include documentation supporting the attestations made by the main provider as to how the facility complies with the applicable requirements of the provider-based regulation. While providers are not required to submit an attestation seeking a determination of provider-based status, the advantage to doing so is that CMS approval of the facility as provider-based eliminates the risk of retrospective recoveries should CMS later determine that the facility did not actually meet all of the requirements to be treated as provider-based.

CMS Provider-Based Requirements

The following requirements are applicable to all provider-based facilities and organizations, and all of the requirements must be met to qualify for provider-based status. These requirements expect the provider-based location to act, operate, and look like the main provider does in all that they do in order to be integral to the main provider. Any deviation in how the provider-based location operates from the main provider could jeopardize an organization's provider-based status, and thus provider-based reimbursement. To help prepare an organization, use the CMS provider-based attestation document that the applicable Medicare administrative contractor (MAC) has posted on its website as a guide to comply with these rules.[10]

Licensure

The provider-based location must do so under the same licensure of the main provider unless state law indicates differently. Not all states license hospitals, and some states require separate licensure of the provider-based entity, so it is important to verify the applicable state law regarding licensure.

Clinical Integration

Integration of clinical service means that the provider-based location handles clinical services in the same manner as the main provider by doing the following:

- All clinical staff must have the same level of medical staff privileges as those at the main provider. For example, the physicians at the provider-based location must have the same privileges as the same type of physicians at the hospital.
- The same level of monitoring and oversight must take place at the provider-based location like it does at the main provider. These locations cannot be "on an island on their own," with no supervision by the main provider.
- The medical directors of the provider-based location must report to someone at the main provider and have the same expectations (including responsibilities, supervision, and accountability) as any other main location medical director.
- Committees (such as medical director or a comparable committee) at the main provider must be responsible for the provider-based location. These committees must treat medical activities such as utilization review, quality, and coordination the same as the main provider.

- All medical records must be in the main provider's unified medical record system.
- Patients from the provider-based location must have access to all inpatient and outpatient services at the main provider.

Financial Integration

Financial operations must also be integrated with the main provider, and proof of this integration must exist. Examples of financial integration include shared income/expenses along with the costs of the provider-based location being reported on the main provider's cost report. Financial integration proof may be required when submitting a provider-based attestation via a trial balance report showing the integration truly exists.

Public Awareness

The provider-based location must present itself as a location of the main provider. When patients walk in to the provider-based location, it must be obvious that they are entering a location of the main provider and that they will receive a bill from the main provider.

In addition to entry signage, other forms of marketing and advertising, such as website information, internal wayfinding signs, patient documents (e.g., registration and letterhead), and advertisements, must include the evidence that the provider-based location is part of the main provider. In the event of submitting an attestation, proof of public awareness is required to be submitted in the form of pictures.

Public awareness and signage are also important for CMS enrollment procedures as well as provider-based rules. CMS uses a separate contractor (National Site Visit Contractor (NSCV)) to make site visits to Medicare-enrolled providers to ensure the site truly exists, that the site is capable of providing services as expressed on the enrollment documents, etc.[11] Proper and obvious signage of a provider-based location can also assist in assuring the enrollment process is seamless.

Public awareness includes how the phones are answered—do the patients know that they are calling a provider-based location? The enrollment departments of CMS also verify how the phones are answered during the enrollment process.

Lastly, patient signage is not only important in meeting the spirit of the various rules mentioned, but for the simple matter of avoiding patient confusion. If patients enter a multi-tenant building with more than one Medicare provider, signage simply helps patients understand where they are at, where they will receive services from, and where they will get a bill from. All it takes is one patient complaint about getting a bill from a hospital they feel they never visited to launch an inspection from CMS or a state agency.

Pay special attention to any state law on signage requirements as well—some states have specific rules on signage requirements for provider-based locations. The state of Washington, for example, has rules on signage and other requirements for provider-based facilities.[12]

Requirements Applicable to Off-Campus Hospital Outpatient Departments (HOPDs) and Hospital-Based Entities

Ownership and Control

The provider-based location must be 100% owned and operated by the main provider and have the same

governing body (i.e., the hospital board).[13] This also means that the provider-based locations fall under the same rules, including human resources (HR) policies, contract approvals, and bylaws, as the main provider as further evidence that the location is truly part of the main provider.

Administrative and Supervision

All administrative operations and supervision of the provider-based location must also be performed by the main provider and its existing departments.[14] This includes the leadership of the provider-based location reporting up to someone from the main provider, in the same fashion as reporting occurs by employees of the main provider, with the same level of intensity and frequency.

All administrative operations (such as billing, human resources, medical records, finance, and supply chain) must be integrated with the main provider. This should be evidenced in the form of operations (e.g., the provider-based location should not have a separate HR department or a separate process for purchasing), and this should be documented on organizational charts. The leadership from the main provider is ultimately responsible for the operations of the provider-based location.

Location

CMS requires the provider-based location to be located within 35 miles of the main provider.[15] Measurement of the distance between the main provider and a potential provider-based location does not have to done via driving directions; the measurement can be done via a measurement of distance as the crow flies. In addition, there are exceptions to the 35-mile rule that account for whether the provider-based location is owned by a disproportionate share hospital (DSH) with an adjustment of 11.75% or greater or if at least 75% of the patients served at the provider-based location reside in the same zip code.[16] A careful analysis of the location exceptions is necessary if a facility does not meet the 35-mile rule.

Special Rules for HOPDs and Hospital-Based Entities to Qualify for Provider-Based Status

EMTALA: The Emergency Medical Treatment and Labor Act, also known as the "anti-dumping" rule, requires all patients be provided a medical screening exam and stabilization of an emergent medical condition and, if necessary, transfer to another facility, regardless of their ability to pay.[17]

Physician billing using correct POS codes:[18]

- To assure appropriate payment based on the provider-based location where the services were provided, the correct POS must be appended to the professional claim form (the CMS-1500 claim form).[19] If the location is an off-campus hospital, POS code 19 would be required, whereas POS code 22 would be used for on-campus hospital. Use of POS code 11 (office) would be inappropriate and would cause an overpayment to the physician.
- When working with independent providers in these locations, expressing this requirement in a written agreement would be advisable to assure these providers understand what type of location they are treating patients at and bill Medicare appropriately.

Provider-based locations of hospitals must comply with the hospitals' Medicare provider agreements, which incorporate the conditions of participation:[20] This includes the prohibition about sharing of clinical space and compliance with life safety code as set forth in 42 C.F.R. § 482 .

Compliance with the nondiscrimination requirements must be met by all providers working in the provider-based location:[21] The main provider should already have a policy in place to assure compliance with 42 C.F.R. § 489.10 , with which the provider-based location must also comply. At a high level, this condition of participation prohibits discrimination based on race, color, national origin, age, and disability.

Must treat all Medicare patients as hospital outpatients:[22] Patients treated in the provider-based locations must be treated as hospital outpatients at all times; there should not be times where some are treated as physician office and others as hospital outpatients. Remember, hospital space is hospital space 24/7, and this is the same for any type of patient.

Three-day payment window:[23] Under the three-day payment window rule, any outpatient services provided within three days of a hospital admission must be included on the inpatient claim (i.e., they will not be paid separately). When thinking about provider-based clinics of a hospital, payment for services provided in these locations would be affected by the three-day rule.

Required written notice of beneficiary coinsurance liability:[24]

- When a patient is treated at an off-campus provider-based location of a hospital, the hospital must provide a notice of coinsurance prior to the service being provided. This notice is to inform the patient that the services they are about to receive will be subject to a coinsurance from both the physician and the hospital and to advise the patient of the amount of the potential financial liability. Many patients are surprised and upset by this when they receive two bills. This is likely one of the biggest issues with provider-based billing—patients feel they are being double-billed.
- If an exact amount of the patient's potential financial liability is not known, an estimate can be given.
- If the patient is unable to receive the notice, this notice can be given to the patient's representative.
- If the services provided to the patient were in accordance with EMTALA, the notice can be given after the patient has been stabilized.

Additional Provider-Based Requirements Depending on Particular Facts

Under Arrangements

Medicare COPs require hospitals to provide certain minimum services in order to qualify as a hospital. Hospitals do not have to provide all of those services themselves though. Hospitals can arrange for some required services to be provided "under arrangements" with another entity by entering into an agreement with that entity. However, the provider-based regulation prohibits facilities and organizations from qualifying for provider-based status if all patient care services furnished at the facility or organization are furnished under arrangements.[25]

Special Rules for Joint Ventures

In order for a facility or organization operated as a joint venture to be considered provider-based, it must meet the following additional requirements:[26]

- Must "be partially owned by at least one provider" and
- Must "be located on the main campus of a provider who is a partial owner" and be provider-based to that

provider.

Special Rules for Management Contracts

Off-campus facilities or organizations that wish to be treated as provider-based must meet the following additional requirements if operated under a management contract:[27]

- The main provider (or an organization that employs the staff of the main provider and is not the management company) must employ the staff who are directly involved in the delivery of patient care:
    - Exception: Management staff and staff who furnish patient care of a type that would be paid for by Medicare on a fee schedule.
    - May not use "leased" employees from the management company for the delivery of patient care (except for staff paid on a fee schedule as described above);
- "The administrative functions of the facility or organization are integrated with those of the main provider."
- "The main provider has significant control over the operations of the facility or organization."
- The management contract must be held by the main provider itself and not by a parent organization.

Medicare Payment Implications of Provider-Based Status for HOPDs and Hospital-Based Entities

As mentioned previously, Medicare payments for services furnished in provider-based clinics and departments of hospitals were historically often significantly higher than payments for the same services furnished in a freestanding facility or physician office. This payment differential was a motivation for hospitals to designate off-site locations (often physician offices) as provider-based to the hospital. But this payment differential also often resulted in higher beneficiary coinsurance liability, because two claims are submitted to Medicare—one by the hospital and one by the physician or other professional—both of which carry beneficiary coinsurance liability, which in most cases is 20% of the Medicare payment.

In light of the higher Medicare reimbursement for these services furnished in provider-based locations and the higher beneficiary costs, provider-based status has been targeted for review and reform in recent years. Dating back to 1999, the Office of Inspector General (OIG) has expressed concerns about and identified vulnerabilities associated with the provider-based status designation.[28] These include oversight challenges and increased costs to Medicare and its beneficiaries, with no documented benefits. Although CMS had taken some steps to address concerns raised by the OIG over the years, it was Section 603 of the Bipartisan Budget Act (BBA) of 2015 that truly changed the course for hospital provider-based departments.[29] Section 603 of the BBA applies to any provider-based off-campus departments that were not billing as a hospital department as of November 2, 2015 (the effective date of the 2015 BBA). As a result, effective January 1, 2017, any hospital off-campus outpatient departments that were not billing Medicare as a hospital department under the OPPS as of November 2, 2015, are subject to "site-neutral" payments, meaning that the hospital's services are not reimbursable under the OPPS and will instead be paid under another system, the Medicare physician fee schedule.[30] However, the BBA of 2015 carved out certain exceptions to this site-neutral payment rule, allowing certain off-campus hospital outpatient departments to continue to receive the higher OPPS payments. As of January 1, 2017, no off-campus hospital outpatient department may be paid under the Medicare OPPS unless (i) it is a dedicated emergency department

(DED), and (ii) it is excepted.[31]

All services furnished at DEDs continue to be reimbursed under the OPPS. For purposes of the provider-based rule and OPPS reimbursement, a DED is defined by the EMTALA definition as:[32]

- Licensed by the state 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
- Providing at least one-third of all of its outpatient visits for the treatment of emergency medical conditions.

The 21st Century Cures Act (Cures Act),[33] which was signed into law on December 13, 2016, revised Section 603 of the BBA of 2015 and established three new exceptions to the site-neutral payment rule established in the BBA of 2015 for off-campus hospital provider-based locations.[34][35] The first exception addressed off-campus provider-based departments that were under development but not billing as provider-based for services as of November 2, 2015 (the effective date of the BBA of 2015) and submitted a voluntary provider-based attestation to CMS before December 2, 2015.[36] This category of off-campus provider-based departments was only temporarily grandfathered and able to continue OPPS payments through 2017.

The second exception was for off-campus provider-based departments that were "mid-build" as of November 2, 2015.[37] Under the Cures Act, "mid-build" meant that the provider entered into a binding written agreement with an unrelated third party for the actual construction of an off-campus provider-based department prior to November 2, 2015. These off-campus provider-based departments were permitted to bill for services under the OPPS as of January 1, 2018, if they:[38]

- Submitted a certification to CMS from their chief executive officer or chief operating officer by February 13, 2017, certifying that the off-campus provider-based department met the definition of "mid-build."
- Submitted an attestation to CMS by February 13, 2017, stating that the off-campus provider-based department meets the requirements of being provider-based.
- Added the new off-campus provider-based department to the hospital's Medicare enrollment form.

Many hospitals took advantage of the mid-build exception and submitted the required certification and attestation and added the new off-campus provider-based department to their Medicare enrollment form. In early 2021, CMS issued determinations on whether those hospital off-campus departments qualified for the mid-build exception and were eligible to receive OPPS reimbursement.[39]

The third exception from the Cures Act added an exemption for certain cancer hospitals as long as the cancer hospital submitted an attestation to CMS within 60 days of the latter of either February 13, 2017, or the date the cancer hospital met the provider-based requirements.[40]

Excepted versus Nonexcepted Status

What does it mean to be "excepted" for purposes of the provider-based rule and OPPS reimbursement? Excepted provider-based locations are:[41]

- Off-campus HOPDs that were furnishing OPPS services prior to November 2, 2015, that have not

impermissibly relocated or changed ownership;

- Off-campus HOPDs that qualify under the mid-build or cancer hospital exception; and
- HOPDs on the campus or within 250 yards of the main hospital or a remote location of a multi-campus hospital.Note: Remote locations are considered off-campus of the main hospital, but locations within the distance (i.e., within 250 yards) of a remote location are excepted.

If an excepted HOPD loses its excepted status for any reason, it will not be able to regain excepted status and will no longer be eligible for OPPS reimbursement.

Effect of Relocation on Excepted Status

As indicated previously, off-campus HOPDs that were furnishing OPPS services prior to November 2, 2015, that have not impermissibly relocated are considered excepted. The BBA of 2015 did not address whether excepted off-campus HOPDs can physically relocate and keep excepted status, but CMS (based on its belief that the intent of the BBA of 2015 was to except only off-campus HOPDs *as they existed prior to November 2, 2015*) stated in the 2017 Medicare OPPS final rule that if an excepted off-campus hospital outpatient department moved from the address on its CMS enrollment form as of November 1, 2015, to a new address, including a change of unit or suite number, the entire off-campus HOPD loses its excepted status.[42] CMS finalized a limited exception for relocation of excepted off-campus provider-based departments due to extraordinary circumstances, such as natural disasters and seismic building code requirements for public health or public safety reasons but not for business reasons such as loss of lease.[43] To use this exception, hospitals must submit a request for an extraordinary circumstances relocation request to CMS within 30 days of the date the "extraordinary circumstance" occurred.[44] The CMS Regional Offices have responsibility for approving/denying these relocation requests.[45]

Effect of Change of Ownership on Excepted Status

Changes of ownership can also affect a provider-based HOPD's excepted status. Excepted off-campus HOPDs that undergo a change in ownership will retain their excepted status and continue OPPS payments if:[46]

1. The same entity acquires the entire hospital, including the off-campus provider-based department, and
2. The new owner accepts assignment of the hospital's Medicare provider agreement.

An excepted off-campus HOPD cannot be transferred from one hospital to another and maintain excepted status. In addition, if an operator combines two certified entities under one provider number, the off-campus HOPDs of the nonretained hospital would lose excepted status.

Medicare Billing and Reimbursement for Services Provided in Excepted and Nonexcepted Provider-Based Departments of Hospitals

As noted previously, on-campus HOPDs and excepted off-campus HOPDs are paid by Medicare under the OPPS for most services. Since CMS does not maintain a list of excepted and nonexcepted HOPDs, excepted off-campus HOPDs must affix the PO modifier to their claims to indicate their excepted status, even if the particular service being billed isn't paid under the OPPS or there's no payment difference for the particular item or service.[47] Nonexcepted off-campus hospital outpatient departments are paid at the lower rate under the Medicare Physician Fee Schedule and must add the PN modifier to their claims to indicate their nonexcepted status. CMS

expects hospitals to report the PN modifier with each nonexcepted line item and service *including those for which payment will not be adjusted*, such as separately payable drugs, clinical laboratory tests, and therapy services.

The most commonly billed HOPD code under the OPPS is G0463 (hospital outpatient clinic visit for assessment and management of a patient). Historically, this code paid significantly more than the equivalent office visit codes under the Medicare Physician Fee Schedule. In November 2018, CMS released the 2019 OPPS final rule finalizing its proposal to make payments for clinic visits "site-neutral" by reducing payments for clinic visits in excepted hospital off-campus provider-based departments by 60%, which is the Medicare Physician Fee Schedule equivalent rate and the same rate it currently pays for the clinic visits furnished in nonexcepted off-campus hospital outpatient departments.[48] The payment reduction was phased in so that payments for the G0463 code were reduced by half of the total reduction in 2019 (equal to payment at 70% of the OPPS rate) and again by half of the total reduction in 2020 (equal to 40% of the OPPS rate).[49]

Options for Expanding Hospital Outpatient Services

With the inability to open new provider-based HOPDs that are reimbursed by Medicare under the OPPS since the passage of BBA of 2015, hospitals have looked for ways to provide more services in their existing provider-based locations and still be paid under the OPPS. What can hospitals do to expand their outpatient hospital services outside the four walls of the hospital?

Focus on On-campus Expansion

Because the Medicare payment cuts apply only to *off-campus* HOPDs, hospitals can add new provider-based departments on-campus (i.e., within 250 yards of any point on the main hospital buildings or a remote location of a hospital) and receive OPPS reimbursement.

Expand the Services in Existing Provider-Based Locations

CMS has twice proposed regulations (first in the 2017 OPPS proposed rule and again in the 2019 OPPS proposed rule) that would have limited hospitals' ability to expand the services provided at existing grandfathered HOPDs to what CMS referred to as the same "clinical family" of services that the hospital was providing at the location as of a specified baseline period. Under the proposed rules, if an excepted off-campus HOPD was to furnish services from any clinical family of services from which it did not previously furnish services during the baseline period, the services from the new clinical family would not be covered by Medicare as outpatient department services and would not be paid under OPPS. They would instead be paid under the Medicare Physician Fee Schedule (MPFS). However, CMS chose not to finalize the clinical family of services rule both times, instead indicating that it would continue monitoring the expansion of services in off-campus provider-based departments and that it may propose to adopt a limitation on the expansion of excepted services in the future.

Reconfigure Existing Off-Campus Provider-Based Locations

The BBA of 2015 bars hospitals from relocating most excepted off-campus HOPDs from the United States Postal Service address, including suite number, indicated on the CMS Form 855A and in the hospital's Medicare enrollment records as of January 1, 2015.[50] If an excepted HOPD impermissibly relocates, the hospital will lose OPPS reimbursement for the location. Limited reconfiguration of a suite or building may be permitted to expand the footprint of an existing post office address (e.g., adding an addition or taking over an adjacent suite and incorporating it into the existing postal address). While CMS has not commented as to the permissibility of such an expansion, it is not prohibited under the rules and guidance CMS has issued to date.

Expand the Services Furnished in Freestanding Emergency Departments

Services furnished at dedicated emergency departments (DEDs) continue to be reimbursed under the OPPS, and there is no rule that all of the services furnished in a DED have to be furnished on an emergent basis rather than on a scheduled or other nonemergent walk-in basis. In fact, under the EMTALA definition of DED, only a minimum of one-third of all of the DED's outpatient visits need to be for the treatment of emergency medical conditions to qualify as a DED.[51] That creates an opportunity for hospitals with satellite freestanding DEDs to furnish other outpatient services in those locations. CMS has noted its concerns about significant growth in the number of healthcare facilities located apart from hospitals that are devoted primarily to emergency department services and overall growth in emergency department services. As a result, CMS implemented a policy requiring that hospitals report the modifier ER on all claim lines for all outpatient hospital services (both emergency and nonemergency) furnished in an off-campus provider-based emergency department on the UB-04 form (CMS Form 1450).[52] The new modifier "ER" will allow CMS to collect data on the types of services furnished in off-campus emergency departments, which are exempt from the payment reductions affecting nonexcepted off-campus HOPDs, but currently has no effect on the rate of payment.[53]