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By Nina Youngstrom

Before a North Dakota hospital could turn a new primary care clinic into a provider-based department, it had to run the compliance gauntlet. The hospital, owned by Catholic Health Initiatives (CHI), answered questions on a provider-based self-audit tool and met with people from finance, compliance and revenue cycle. It was a good thing because that's how Sheri Heinisch, regional corporate responsibility officer for CHI in Fargo, heard the hospital planned to lease space to a visiting specialist. Medicare only allows so-called co-location if strict provider-based requirements are met relative to physical space, and failure to satisfy them can lead to a loss of provider-based status. The hospital wasn't taking any chances; it found non-hospital space for the visiting specialist, Heinisch says. That was a relief, but the near miss was a reminder of the importance of vetting provider-based space.

The potential for compliance problems—and recent payment cuts—are forcing more careful examination of provider-based space. The calculus of whether the costs of provider-based space outweigh the benefits has changed because of Sec. 603 of the Bipartisan Budget Act of 2015, CMS's site neutrality payment policy of 2019 and more bundling of charges under the outpatient prospective payment system (OPPS), all of which may make freestanding clinics a more attractive option in some cases depending on reimbursement, 340B drugs, location and patient population. Meanwhile, compliance mistakes may run the gamut, from billing for services provided incident to the physician's services to dropping modifiers off claims.

Oncology Clinics Are Usually Provider Based

For some services, it's usually a no-brainer to go with provider-based space. For example, most oncology and rheumatology clinics, longstanding or brand new, will be provider based, even with payments cuts from Sec. 603 and site neutrality, says Jill Anderson, assistant director of compliance for the physician network at Novant Health, which has 15 hospitals and hundreds of outpatient centers and physician offices in North and South Carolina and Virginia. The high cost of oncology and rheumatology infusion makes maintaining access to the 340B drug discount program worth absorbing the blows to provider-based space. For other types of outpatient services, it's a case-by-case decision. "Every single project is individually considered," Anderson says. "It's case-by-case basis depending on the services the clinic will render."

Novant Health has a task force to evaluate whether proposed physician offices and clinics should be provider based or freestanding. The task force, which includes compliance, revenue cycle, billing, government relations, credentialing and the electronic health records team, looks at how new clinics would fare from a revenue and reimbursement perspective, Anderson says. They're subject to Sec. 603, which ended OPPS payments for off-campus provider-based departments established after Nov. 2, 2015. They are now paid 40% of the OPPS rate under the Medicare Physician Fee Schedule (MPFS). And there's site neutrality, which means Medicare is phasing in the same rate payment for clinic visits (G0463) whether patients are seen in provider-based space or freestanding clinics. Provider-based departments still have advantages, including separate facility fees and professional fees for other services, and 340B drug discounts. But Medicare now bundles a lot of provider-based services under OPPS, while most services are reported and paid separately to freestanding clinics, Anderson

explains.

The task force meets twice a month, and usually evaluates two or three proposals. For example, it would assess whether a potential oncology clinic that's opening a satellite location should be provider based or freestanding. A threshold question is how far away the site is from the main hospital. Off-campus provider-based space has to be located within 35 miles of the host hospital, and on-campus provider-based space within 250 yards. It's a little more complex with remote hospital locations, however. "If you're within 250 yards of the remote hospital, you are still considered off campus of the host hospital but are exempt from the reimbursement reductions, much like the on-campus provider-based locations," Anderson says.

For an oncology clinic, provider based is a virtual certainty because 340B drugs are available to hospital outpatient departments. The same applies to clinics for rheumatology infusion. "If we purchase drugs outside 340B"—which is the case with freestanding clinics—"it's very expensive for the clinics to buy them," Anderson says.

However, Heinisch notes that freestanding clinics are eligible for 340B drugs under certain circumstances. If they're a reimbursable cost center on the hospital's cost report, freestanding clinics may participate in the 340B program, she says.