Program Memorandum Intermediaries

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2411

SUBJECT: Provider-based Status On or After October 1, 2002

Regulations in 42 CFR §413.65 describe the criteria and procedures for determining whether a facility or organization is provider-based. The Medicare Hospital Inpatient Prospective Payment System final rule published on August 1, 2002 (67 FR 50078) revised those regulations effective on October 1, 2002, for facilities or organizations that are not grandfathered as provider-based as described below and, in the case of grandfathered facilities, effective for main provider cost reporting periods beginning on or after July 1, 2003. This Program Memorandum (PM) provides information on the background of the provider-based regulations and notifies you of the actions you are to take to implement the revised regulations.

NOTE: This PM supersedes program instructions concerning provider-based status in §2446 of the Provider Reimbursement Manual, Part I (PRM-I) and §2004 of the State Operations Manual (SOM) that apply to any facility for periods before the regulations at 42 CFR §413.65 become applicable to it.

A. Background

1. Current Regulations

Since the beginning of the Medicare program, some providers, which we refer to as "main providers," have functioned as single entities while owning and operating multiple provider-based departments, locations, and facilities that were treated as part of the main provider for Medicare purposes. Having clear criteria for provider-based status is important because this designation can result in additional Medicare payments for services furnished at the provider-based facility, and may also increase the coinsurance liability of Medicare beneficiaries for those services.

In the April 7, 2000, **Federal Register** (65 FR 18504), we published a final rule specifying the criteria that must be met for a determination regarding provider-based status. The regulations at existing 42 CFR §413.65(b)(2) apply the same criteria to facilities on the main provider campus as to off-campus facilities, and state that before a main provider may bill for services of a facility as if the facility is provider-based, or before it includes costs of those services on its cost report, the facility must meet the criteria listed in the regulations. Those regulations were first effective for cost reporting periods beginning on or after January 10, 2001.

2. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of December 2000

On December 21, 2000, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 (Public Law 106-554) was enacted. Section 404 of BIPA contained provisions that significantly affected the provider-based regulations at §413.65. Under §404(a) of BIPA, any facilities or organizations that were "treated" as provider-based in relation to any provider on October 1, 2000, are to continue to be treated as such until October 1, 2002. "Facilities treated as provider-based" include those facilities with formal CMS determinations, as well as those facilities without formal CMS determinations that were being paid as provider-based as of October 1, 2000. As a result, facilities and organizations meeting the BIPA description were allowed to continue to be

treated as provider-based without meeting most of the criteria in the existing regulations until October 1, 2002. Those facilities and organizations affected under §404(a) of BIPA also were not required to submit an application for or obtain a provider-based status determination in order to continue receiving reimbursement as provider-based during this period.

3. Further Delay in Effective Date of Provider-Based Rules

Regulations implementing the BIPA §404 provisions were published in final on August 1, 2002. Under the August 1, 2002, revision to the provider-based regulations, if a facility was treated as provider-based in relation to a hospital or a critical access hospital (CAH) on October 1, 2000, it will continue to be considered provider-based in relation to that hospital or CAH until the start of the hospital's first cost reporting period beginning on or after July 1, 2003. (The new requirements are effective on October 1, 2002, with respect to provider-based status for facilities not in existence on October 1, 2000, or not treated as provider-based in relation to a hospital or CAH on that date.)

4. Criteria for Temporary Treatment as Provider-Based, Utilized Before Oct. 1, 2002

Section 404(c) of BIPA provides that a facility or organization that seeks a determination of provider-based status on or after October 1, 2000, and before October 1, 2002, shall be treated as having provider-based status for any period before a determination is made. Thus, recovery for overpayments will not be made retroactively once a request for a determination during that time period has been made. Once such a request has been submitted on or after October 1, 2000, and before October 1, 2002, CMS will treat the facility or organization as being provider-based from the date it began operating as provider-based until the effective date of a CMS determination that the facility or organization is not provider-based.

The provision concerning temporary treatment as provider-based in §04(c) of BIPA is effective only for requests filed on or after October 1, 2000 and before October 1, 2002.

B. Information on the Attestation Process Beginning on or After Oct. 1, 2002

1. Is an attestation required?

Effective October 1, 2002, the mandatory requirement for provider-based determinations under §413.65(b) has been replaced with a voluntary attestation process. Providers are no longer required to apply for and receive a provider-based determination for their facilities prior to billing for services in those facilities as provider-based. However, under §413.65(b)(3), a provider may choose to obtain a determination of provider-based status by submitting an attestation stating that the facility meets the relevant provider-based requirements (depending on whether the facility is located on campus or off campus). Providers who wish to obtain such a determination of provider-based status for their facilities after October 1, 2002, should do so through the self-attestation process.

2. Should grandfathered facilities submit self-attestations?

As noted above, facilities treated as provider-based in relation to a provider on October 1, 2000, are not affected by the revised regulations until the main provider's first cost reporting period starting on or after July 1, 2003. In the case of these grandfathered facilities, any attestation regarding provider-based status will be considered only with respect to periods on or after that effective date.

3. What are the benefits of self-attesting?

Effective October 1, 2002, (or, for grandfathered facilities, effective for the potential main provider's first cost reporting period starting on or after July 1, 2003), an attestation of provider-based status, if approved, would result in a determination that a facility or organization is provider-based.

If CMS subsequently discovers that the facility for which an attestation has been made and approved in fact does not meet the provider-based rules, then CMS would not recover all past payments for periods subject to reopening, but instead would recover only the difference between the amount of payment that actually was made since the date the complete attestation for a provider-based determination was submitted and the amount of payments that CMS estimates should have been made in the absence of compliance with the provider-based requirements during that time period. For example, if a facility opens and begins billing as provider-based on October 1, 2002, and the

potential main provider submits an attestation on December 1, 2002, and the attestation is disapproved by CMS on February 1, 2003, then CMS will only recover the overpayments since December 1, 2002. In addition, at the time that CMS determines that a facility, that submitted a complete attestation, is actually not provider-based, payment would continue for up to 6 months but only at a reduced rate as described at §413.65(j)(5). However, if that main provider had not submitted an attestation and CMS determined that the facility is not provider-based, CMS would recover the overpayment for the period beginning October 1, 2002.

It could also benefit the provider to self-attest and obtain a determination because, under §413.65(l)(1), where a material change subsequently occurs in the relationship between the facility or organization and the main provider, and the main provider properly reports the material change to CMS, then treatment of a facility as provider-based would cease only with the date that CMS determines that the facility no longer qualifies for provider-based status. By contrast, a provider that does not self-attest at all, or does obtain a determination but fails to report a subsequent material change in its relationship with the facility, could face a recovery of the difference between provider-based and freestanding payment (i.e., the overpayment). For example, if a main provider opens a facility and begins billing as provider-based on October 1, 2002, but does not submit an attestation nor does the facility qualify as provider-based under § 413.65, and CMS discovers on February 1, 2003 that the main provider is billing inappropriately as provider-based, then CMS will recover the overpayments since October 1, 2002.

4. Who is responsible for processing the attestations and making provider-based determinations?

The fiscal intermediaries (FIs) will receive and review the attestations. The providers should submit the original attestations (and documentation for off-campus facilities) to the FI, and submit an identical copy of the attestations (and documentation for off-campus facilities) to the regional office (RO) for the State in which the main provider is located. This will alert the ROs as to which providers are submitting attestations, and to expect a recommendation of approval or denial of provider-based status from the FIs for those providers.

However, all final determinations as to whether particular facilities or organizations are provider-based are to be made by the RO for the State in which the potential main provider is located. The FI for the potential main provider may make a recommendation to the RO as to whether the attestation should be accepted. The RO should either approve or disapprove the recommendation and notify the provider and the FI of its decision as to the status (provider-based or freestanding) of the facility or organization.

There are some providers who are serviced by FIs that are not under the same RO jurisdiction as the main provider. For example, a main provider may be physically located within the geographic jurisdiction of the Philadelphia RO, but the main provider may be serviced by a FI that is under the jurisdiction of the Dallas RO. In such cases, the RO for the State in which the main provider is located has jurisdiction over the provider-based determinations. Thus, for example, although a main provider in Pennsylvania may be serviced by an FI that is headquartered in Texas, the Philadelphia RO has jurisdiction over provider-based determinations made for the main provider located in Pennsylvania. Because the final decision as to whether the main provider's facilities are provider-based will be made by the RO for the State in which the main provider is located, the RO may need to coordinate the review process with multiple FIs, and another RO. Furthermore, although the "home" RO for the main provider has final jurisdiction for provider-based decisions, the RO with oversight of the servicing FI should be copied on and informed of all decisions the FI is asked to implement or otherwise is involved with.

5. Is there a required form that must be used for attestations?

No, a provider may use a letter, memo, or any other format that contains the necessary information, although this PM contains an example of an acceptable format for the attestation.

6. What should be included in the attestation?

Under §413.65(b)(3), a complete attestation is one that includes all information needed to permit CMS to make a determination. We have attached a sample attestation form that may, but is not required, to be used by the providers. At a minimum, an attestation should include:

- The identity of the main provider and the facilities or organizations for which provider-based status is being sought,

- An enumeration of each facility and a statement of its exact location (that is, its street address and whether it is on campus or off campus),

- Supporting documentation for off-campus facilities for purposes of applying the provider-based status criteria in effect at the time the request or attestation is submitted,

- The date on which the facility became provider-based to the main provider, and

- Information on the person to contact should CMS or the intermediary have further questions.

Other required content for an attestation will depend on whether or not the facility is located on the main campus of the potential main provider. For purposes of the provider-based regulations, "campus" means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by CMS, to be part of the provider's campus. Attestations for on-campus facilities must attest to meeting the items in paragraph C below. Attestations for off-campus facilities must attest to meeting and provide documentation for the items in paragraphs C and D below.

The following sections C and D list the requirements for attesting to provider-based status for on-campus and off-campus facilities, respectively, and specify ways in which the provider would document that the facility meets the particular requirement. At any time during the review of an attestation, either for on-campus or off-campus facilities, the RO or the FI may ask the provider for any documentation or information that they feel is necessary to make a determination.

C. Content of Attestations for on-campus facilities

If a potential main provider seeks a determination of provider-based status for a facility that is located on the main campus of the potential main provider, the provider must submit an attestation containing the identifying information described in paragraph (B)(6) above, and stating that its facility meets each of the criteria in §413.65(d) listed below. If the potential main provider is a hospital, it must also attest that its facility will fulfill the obligations of hospital outpatient departments and hospital-based entities, as described in proposed §413.65(g). The provider must maintain documentation of the basis for its attestations and make that documentation available to CMS and to its FI upon request.

For attestations submitted for on-campus facilities, the FI should confirm that the facility is in fact on-campus. A map of the campus, use of mapping software such as Mapquest, or an onsite visit to the facility may be necessary to determine the facility's location.

The criteria at §413.65(d) that are applicable to <u>all</u> facilities, including those on-campus, are:

1. <u>Licensure</u>

The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If a State health cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, CMS will determine that the facility or organization does not have provider-based status.

Documentation maintained by the provider may include a copy of the State license, including the license number and the expiration date. Where applicable, the provider may need to maintain documentation of whether the State where the entity is located requires a separate license for the facility requesting provider-based status.

2. Clinical Services

The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(a) Professional staff of the facility or organization have clinical privileges at the main provider.

(b) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(c) The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(d) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

Documentation maintained on (a)-(d) may include a list of all personnel working at the facility or organization showing their job titles and name of their employer, information as to whether professional staff of the facility have clinical privileges at the main provider, a description of the level of monitoring and oversight of the facility by the main provider as compared to oversight for another departments of the main provider, and a description of the responsibilities and relationships between the medical director of the facility, the chief medical officer of the main provider, and the medical staff committees at the main provider.

(e) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross-reference) of the main provider.

The provider may maintain a copy or description of the policy utilized in record retrieval from both the main provider and the facility requesting provider-based status.

(f) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

For example, the provider could maintain information on how inpatient and outpatient services of the facility and the main provider are integrated, and examples of integration of services, including data on the frequency of referrals from inpatient to outpatient facilities of the provider, or vice versa.

3. Financial Integration

The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.

Documentation maintained by the provider could include a copy of the appropriate section of the main provider's chart of accounts or trial balance that would show the location of the facility's revenues and expenses.

4. Public Awareness

The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

As documentation, the provider may maintain examples that show that the facility is clearly identified as part of the main provider (i.e., a shared name, patient registration forms, letterhead, advertisements, signage, Web site). Advertisements that only show the facility to be part of or affiliated with the main provider's network or healthcare system are not sufficient.

5. Obligations of Hospital Outpatient Departments and Hospital-based Entities

In the case of a hospital outpatient department or a hospital-based entity, the facility or organization must fulfill the obligations of hospital outpatient departments and hospital-based entities as described in §413.65(g)(1) through (6) and (g)(8). The term "hospital," as used in connection with these obligations, includes a critical access hospital (CAH). These obligations include:

(a) Hospital outpatient departments located either on or off the campus of the hospital that is the main provider must comply with the antidumping rules in §§489.20 (l), (m), (q), and (r) and §489.24 of chapter IV of Title 42.

(b) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined.

(c) Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

(d) Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with the non- discrimination provisions in §489.10(b) of chapter IV of Title 42.

(e) Hospital outpatient departments (other than RHCs) must treat all Medicare patients, for billing purposes, as hospital outpatients. The department must not treat some Medicare patients as hospital outpatients and others as physician office patients.

(f) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at §412.2(c)(5) of this chapter and at §413.40(c)(2), respectively.

NOTE: The payment window provisions do not apply to critical access hospitals (CAHs).

(g) Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

Documentation maintained by the provider to document compliance with some of these requirements might include a copy of the EMTALA policy in place at the facility.

6. Provider-based Status for Joint Ventures

In order for a facility or organization operating as a joint venture to be considered provider-based, the facility or organization must:

(a) Be partially owned by at least one provider;

(b) Be located on the main campus of a provider who is a partial owner;

(c) Be provider-based to the main provider on whose campus the facility or organization is located; and

(d) Also meet all the requirements applicable to all provider-based facilities and organizations in §413.65(d).

For example, where a provider has jointly purchased or jointly created a facility under joint venture arrangements with one or more other providers, and the facility is not located on the campus of the provider or the campus of any other provider engaged in the joint venture arrangement, no party to the joint venture arrangement can claim the facility as provider-based. In other words, if Hospital A and Hospital B form a joint venture, but the joint venture facility is not located on the campus of either hospital, then neither Hospital A nor B may claim the facility as provider-based. Additionally, the facility operated as a joint venture must be provider-based only to the provider whose campus on which the facility is located, regardless of whether that provider is the majority owner. For example, if Hospital A owns 60 percent of Facility C, and Hospital B owns 40 percent of Facility C, but Facility C is located on the campus of Hospital B, Facility C may only be provider-based to Hospital B.

The facility does not have to advertise as a joint venture, but as a facility that is provider-based to the main provider. Accordingly, the services in the facility would be billed using the provider number of the provider whose campus on which the facility is located. (The facility cannot, of course, be provider-based with respect to both hospitals.)

D. Content of Attestations for Off-campus Facilities

If the facility is not located on the main campus of the potential main provider, the provider that wishes to obtain a determination of provider-based status must submit an attestation containing the identifying information described in paragraph B.6 and state that its facility meets each of the criteria in paragraph C.1 through C.4 (corresponding to regulations at §413.65(d)) as well as the additional requirements listed below (corresponding to regulations at §413.65(e)). If the facility is operated as a joint venture or under a management contract, the potential main provider must also attest to compliance with the requirements in paragraph C.6 and D.5 (corresponding to §§413.65(f) and 413.65(h)), as applicable. As explained below, if the potential main provider is a hospital, the hospital also must attest that it will fulfill the obligations of hospital outpatient departments and hospital-based entities described in paragraph C.5 and item 4 of this paragraph (corresponding to§413.65(g)).

The provider seeking such a determination must submit documentation of the basis for its attestations to CMS at the time it submits its attestation.

The *additional* requirements applicable specifically to off-campus facilities or organizations are as follows:

1. Operation Under the Ownership and Control of the Main Provider

The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(a) The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.

(b) The main provider and the facility or organization seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.

(c) The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the main provider where it is based.

(d) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the facility or organization.

As documentation for this requirement, the provider may need to furnish documents such as the articles of incorporation and the bylaws for both the main provider and the facility. The provider also may want to describe who has final approval for administrative decisions, contracts with outside parties, personnel policies, and medical staff appointments for the facility.

2. Administration and Supervision

The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:

(a) The facility or organization is under the direct supervision of the main provider.

Documentation furnished by the provider may include a list of key administrative staff (position/titles only) at the main provider and the facility that reflects a reporting relationship.

(b) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity:

(i) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and

Documentation for this requirement may include an organizational chart that includes the main provider and the facility requesting provider-based status.

(ii) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

As documentation, the provider may include a written description of the facility director's reporting requirements and accountability procedures for day to day operations.

(c) The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(i) Contracted out under the same contract agreement; or

(ii) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

Documentation furnished by the provider may include a list of the various administrative functions (e.g., billing services, laundry, payroll) at the facility that are integrated with the main provider. Additionally, the provider may include copies of any contracts for administrative functions that are completed under arrangements for the main provider and/or facility.

3. Location

The facility or organization is located within a 35-mile radius of the campus of the provider that is the potential main provider, except when the requirements in paragraph C.3.a, C.3.b, or C.3.c (corresponding to §§413.65(e)(3)(i), (e)(3)(ii), and (e)(3)(iii)) are met:

(a) The facility or organization is owned and operated by a provider that has a disproportionate share adjustment (as determined under §412.106 of chapter IV of Title 42) greater than 11.75 percent or is described in §412.106(c)(2) of chapter IV of Title 42 implementing §1886(e)(5)(F)(i)(II) of the Act and is:

(i) Owned or operated by a unit of State or local government;
(ii) A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or
(iii) A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

(b) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period:

(i) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;
(ii) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or
(iii) If the facility or organization is unable to meet the criteria in paragraph (e)(3)(ii)(A) or paragraph (e)(3)(ii)(B) because it was not in operation during all of the 12-month period described in paragraph (e)(3)(ii), the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph (e)(3)(ii), accounted for at least 75 percent of the patients served by the main provider.

Note that the 75/75 test under § 413.65(e)(3)(ii)(A) and *§ 413.65(e)(3)(ii)(B) may be demonstrated with any mix of inpatients and/or outpatients of the main provider.*

Providers may submit Excel spreadsheets or other computer files with listings of all patients treated at the hospital and at the facility within the most recent 12-month period. The listing should include the patient's name, medical record number, date(s) of visit, date(s) of discharge, address, city, and zip code. To demonstrate compliance with §413.65(e)(3)(ii)(A), after including the total number of patients from both the facility and the provider, the provider should list each zip code, and the number of patients from that zip code that were treated at the hospital, and the number of patients from that same zip code that were treated at the facility. Alternatively, to demonstrate compliance with §413.65(e)(3)(ii)(B), the provider may submit admissions data that would indicate the reasons the patients served by the facility came to receive treatment at the provider.

(c) A facility or organization may qualify for provider-based status under this section only if the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

(d) An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in §412.62(f)(1)(iii) of chapter IV of Title 42, and has fewer than 50 beds, as determined under §412.105(b) of chapter IV of Title 42, is not subject to the criteria in paragraphs (D)(3)(a) and (b) of this PM (corresponding to §413.65(e)(3)(i) through (e)(3)(iii)).

To demonstrate that a facility is located within a 35-mile radius of the main provider, maps or an online service such as Mapquest may be used. (Note, however, that under this policy, the 35-mile

radius is measured by actual straight-line distance between the provider and the facility, not road miles).

4. Obligations of Hospital Outpatient Departments and Hospital-Based Entities

The obligations for on campus facilities or organizations apply to those off campus, with the following additional obligations:

(a) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, and the treatment is not required to be provided by the antidumping rules in §489.24 of chapter IV of Title 42, the hospital must provide written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability).

(i) The notice must be one that the beneficiary can read and understand.

(ii) If the exact type and extent of care needed is not known, the hospital may furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based.

(iii) The hospital may furnish an estimate based on typical or average charges for visits to the facility, while stating that the patient's actual liability will depend upon the actual services furnished by the hospital.

(iv) If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, before the delivery of services, to the beneficiary's authorized representative.

(v) In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules of §489.24 of chapter IV of Title 42, notice, as described in this paragraph (g)(7), must be given as soon as possible after the existence of an emergency has been ruled out or the emergency condition has been stabilized.

For example, information providers may supply as documentation could include a copy of the form they give to patients and a copy of their policies regarding distribution of the form. Providers may also supply a copy of their policy on EMTALA compliance.

Note that an Advance Beneficiary Notification (ABN) for non-covered services does <u>not</u> meet the requirement of providing written notice of beneficiary liability. Also, notice is not required if the facility furnishes only services for which the beneficiary will not incur any deductible or coinsurance liability, or services for which the beneficiary liability is the same in both the provider-based and freestanding settings (e.g., screening mammography).

5. Management Contracts

A facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of sections C and D of this document, but is operated under management contracts, must also meet all of the following criteria:

(a) The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at part 414 of chapter IV of Title 42. Other than staff that may be paid under such a Medicare fee schedule, the main provider may not utilize the services of "leased" employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

(b) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph D.2.c (corresponding to §413.65(e)(2)(iii)).

(c) The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph D.2.b (corresponding to §413.65(e)(2)(ii)).

(d) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

Main providers are not required to employ other support staff, such as maintenance or security personnel, who are not directly involved in providing patient care, nor are licensed professional caregivers such as physicians, physician assistants, or certified registered nurse anesthetists required to become provider employees. As noted above, other than staff that may be paid under a Medicare fee schedule, the main provider may not utilize the services of "leased" employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing arrangement) that are directly involved in the delivery of patient care.

Providers could include as documentation a copy of any relevant management contracts for the facility.

E. Additional Issues to Consider for Attestations

1. Does a main provider have to submit a separate attestation for each of its facilities and services, on campus and off campus?

The provider-based rules do not apply to specific services; rather, these rules are site-specific. That is, each individual department or entity in its entirety must be a subordinate and integrated part of the main provider. For example, a provider may have several outpatient departments, some located on campus and some located off campus, yet each department as a whole must meet the applicable rules for provider-based status. However, a main provider would not need to submit a separate application for each one of its facilities for which a provider-based determination is sought. A facility or organization may also be viewed as constituting a separate cost center in a main provider's general ledger. A provider may attest in a single application package that each one of its facilities (or cost centers) for which it intends to bill for services as if the facility is provider-based meets the applicable provider-based rules under §13.65. For those facilities that are located on campus, no documentation is required to be submitted with the attestation. Documentation must be submitted for those facilities located off campus. However, we are requiring that as part of its attestation, the main provider enumerate each facility and state its exact location (that is, its street address and whether it is on campus or off campus).

For purposes of provider-based determinations, a facility may be an entire building, two or more buildings, or defined areas within a building. For example, a hospital may lease space in a building that includes numerous physicians' offices, a DME supplier, and some other non-medical offices, in addition to housing the hospital's radiology department and an outpatient clinic. Provider-based status would only apply, however, to the radiology department and the outpatient clinic. Because the provider-based rules are site-specific, the provider would attest to the provider-based status of the radiology department and the outpatient clinic. That is, the provider would attest that each department or entity within that multi-suite building to which the provider-based rules apply, meets the provider-based rules. The provider would *not* attest that the entire building is provider-based, but only that those specific offices or suites where hospital services are provided are provider-based. A provider may need to submit floor plans of such a building in order to document that a department or entity is provider-based.

2. Effective Date of Determinations of Provider-Based Status

Generally, a determination of provider-based status cannot be effective before the earliest date on which an attestation regarding provider-based status has been made and all requirements of 42 CFR Part 413 have been met. See issue #3 below for an exception to this rule.

3. For grandfathered facilities, may a main provider submit an attestation prior to the cost reporting period beginning on or after July 1, 2003 in which the provider-based rules will apply?

Even though the provider-based criteria in §§413.65(d) and (e) do not apply to grandfathered facilities until main provider cost reporting periods beginning on or after July 1, 2003, providers with grandfathered facilities may file an attestation prior to the July 1, 2003 date to attest to

compliance for the main provider's first cost reporting period beginning on or after July 1, 2003. For example, if a main provider with a June 30 fiscal year end has facilities that are grandfathered until June 30, 2003, then, although the main provider may submit the attestation for those facilities prior to July 1, 2003, the provider-based determination made based on that attestation cannot be effective for any period prior to July 1, 2003. Accordingly, the FI has the discretion, but is not required, to review the attestation prior to July 1, 2003. Even if the attestation is reviewed before July 1, 2003, it would not be effective until July 1, 2003. If it is reviewed after July 1, 2003, and if the facility is found to meet the provider-based rules back to July 1, 2003, then CMS can make the determination apply as of July 1, 2003.

4. For new facilities, may a main provider submit an attestation prior to the date that the facility opens?

The FI has the discretion to decide whether attestations submitted for facilities that have not yet opened will be accepted and reviewed. However, the effective date of a determination of provider-based status for a facility that has not yet opened cannot be a date before the facility opens.

5. CMS Action on Attestations and Timeframe

The regulations at §413.65(b)(3)(iii) state that whenever a provider submits an attestation of provider-based status for an on-campus facility or organization, CMS will send the provider written acknowledgement of receipt of the attestation, review the attestation for completeness, consistency with the criteria in §413.65, and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility is provider-based. Unless CMS has reason to believe that the attestation submitted for the on-campus facility is incomplete or inconsistent with the applicable provider-based requirements, CMS may make a provider-based determination on the basis of the attestation, and need not request and review documentation from the provider in support of the attestation. Incomplete attestations should be handled as described in paragraph E.6 below.

In §413.65(b)(3)(iv), we clarified that whenever a provider submits an attestation of provider-based status for an off-campus facility or organization, CMS will send the provider written acknowledgement of receipt of the attestation, review the attestation for completeness, consistency with the criteria in §413.65, consistency with the documentation submitted with the attestation, and consistency with information in the possession of CMS at the time the attestation is received, and make a determination as to whether the facility is provider-based.

6. Relation to Enrollment Approvals

In some cases, a provider may request an enrollment change, such as adding a new practice location for an outpatient clinic that wishes to bill under the provider number of an existing hospital, but may or may not submit an attestation of provider-based status for that practice location. When issuing an approval of an enrollment change of this kind, please inform the provider that such an approval is effective for enrollment purposes only and does not constitute a determination that the facility meets the requirements for provider-based status in 42 CFR §413.65.

7. What actions will be taken if an attestation is incomplete?

If an attestation is found to be incomplete, the provider should be notified in writing of the specific information or documentation needed to complete the attestation, and be given 30 days to submit the missing information or documentation. Depending on the extent of the omissions, the FI may either proceed with its review of the attestation or suspend review until the necessary supplementary information or documentation is received. If the needed material is not received within 30 days, the attestation should be disapproved, and recovery of any overpayments will be made from the date of the disapproval back to the date on which the provider submitted the attestation.

8. What actions will be taken if the attestation (i.e., determination of provider-based status) is denied?

As stated in the response to the previous question #6, in accordance with §413.65(k), recovery of overpayments will be made from the date of the disapproval of the attestation back to the date on

which the provider submitted the attestation. In addition, the RO should issue a notice of denial of provider-based status to the provider explaining that the provider has the following 4 options:

(1) The provider may notify CMS in writing within 30 days of the date the notice is issued that the provider intends to make the changes needed for the facility or organization to comply with the provider-based rules and that the provider intends to seek a determination of provider-based status for its facility or organization. If the provider indicates that it will be seeking a provider-based determination for the facility or organization, then CMS will continue to pay for services provided at the facility or organization at a rate estimated for services furnished by a freestanding facility. CMS will continue to pay at this rate for as long as is required for the facility or organization to comply with the provider-based rules, (but not for longer than 6 months), if the provider submits a complete request (not an attestation) for a provider-based determination and all other required information within 90 days after the date of the notice of denial of provider-based status. If the necessary application or information is not provided, CMS will terminate all payment to the provider, facility, or organization as of the date CMS issues notice that necessary applications or information have not been submitted.

(2) The provider may notify CMS in writing within 30 days of the date the notice is issued that the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a free-standing facility. If the provider indicates that the facility or organization, or its practitioners, will be seeking to meet enrollment and other requirements for billing for services in a free-standing facility, then CMS will continue to pay for services provided at the facility or organization at a rate estimated for services furnished by a freestanding facility. CMS will continue to pay at this rate for as long as is required for the facility or organization to enroll as a freestanding facility, (but not for longer than 6 months), if the facility or organization, or its practitioners, submit a complete enrollment application and furnish all other information needed by CMS to process the enrollment application and verify that other billing requirements are met within 90 days after the date of notice of the denial of provider-based status. If the necessary enrollments or information is not provided, CMS will terminate all payment to the provider, facility, or organization as of the date CMS issues notice that necessary applications or information have not been submitted.

(3) The provider may choose not to notify CMS within 30 days of the date the notice is issued of whether it intends to pursue provider-based status under item (1) above, or freestanding status under item (2) above. If CMS does not receive a response as described in item (1) or item (2) within 30 days of the date the notice is issued, all payment will end as of the 30th day after the date of the notice.

Regardless of whether or how it responds to the notice in items (1) through (3) above, the provider may choose to appeal its denial of provider-based status within 60 days from the date of the notice of denial. Adverse determinations regarding provider-based status may be appealed under the administrative appeals procedures set forth in 42 CFR Part 498. Any notice to the provider of an adverse determination must contain a paragraph informing the provider of its right to appeal under those procedures. The following language may be used to inform the provider of its appeal rights:

> Initial Determination Request for Reconsideration
>
> If you are dissatisfied with this determination, you may request reconsideration by filing a written reconsideration request within sixty (60) days from the date on which you receive this letter. Your request must state the issues or findings of fact with which you disagree and the reasons for disagreement. Your reconsideration rights are set forth in the regulations at 42 CFR §498.22. Please address your request for reconsideration to:
>
> (Insert address of appropriate CMS RO ARA.)
>
> Denial of a Reconsideration Request
>
> If you disagree with this first level appeals determination, you or your legal representative may request a hearing before an Administrative Law Judge (ALJ) of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in the regulations at 42 CFR §498.40 et

seq. A written request for a hearing must be filed within sixty (60) days from the date on which you receive your first level appeal results. The request should be made to:

Departmental Appeals Board
Civil Remedies Division
Room 637-D
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201
Attention: Jacqueline Williams

Forward a copy of your request for an ALJ hearing to:

(Insert address of appropriate CMS RO ARA.)

and

(Insert address of appropriate RO General Counsel.)

A request for a hearing must identify the specific issues and findings of fact and conclusions of law with which you disagree, and specify the basis for contending that the findings and conclusions are incorrect.

9. Is an attestation required before a provider begins billing for services of a facility or organization?

Regardless of whether they are grandfathered under BIPA, providers are not obligated to submit attestations or applications for provider-based status before they begin billing as provider-based. A provider would only be considered to be billing inappropriately if the facility actually did not meet the relevant provider-based rules. However, if a provider does not submit a complete attestation acceptable to CMS of provider-based status, and CMS subsequently determines that the provider is billing inappropriately, the provider would be subject to recovery of overpayments under §413.65(j)(ii) for services at that facility(ies) for all prior cost reporting periods subject to reopening in accordance with §§405.1885 and 405.1889.

10. Does a main provider need to "re-attest" after a certain period of time?

Just as providers are no longer explicitly required to submit an initial attestation, there is also no explicit requirement for hospitals to re-attest that their facilities continue to meet the provider-based requirements. However, §413.65(c) provides information on reporting of material changes in provider-based relationships. Under §413.65(l), if CMS determines that a facility that had previously been determined to be provider-based no longer qualifies for provider-based status, and the failure to qualify for provider-based status results from a material change in the relationship between the main provider and the facility that the main provider reported to CMS, treatment of the facility as provider-based would cease with the date that CMS determines that the facility no longer qualifies for provider-based status. Conversely, if a main provider did not report a material change to CMS, the main provider will be subject to recovery of overpayments as described under §413.65(j)(1)(ii).

11. How should applications for provider-based status that were submitted prior to October 1, 2002 be handled?

As stated above in part A of this PM, §404(c) of BIPA states that facilities for which a request for determination of provider-based status was submitted on or after October 1, 2000 and before October 1, 2002, are treated as having provider-based status for any period before a determination is made. This applies even to those facilities that have submitted applications for a determination during that time period but CMS has *not* yet determined those facilities to be provider-based.

After September 30, 2002, providers no longer submit applications to obtain provider-based determinations under §404(c) of BIPA. Instead, providers wishing to obtain provider-based determinations regarding specific facilities must submit attestations as described above. For those

applications that were submitted on or after October 1, 2000 and before October 1, 2002 for which a determination regarding provider-based status is still pending, rather than have the providers submit attestations, the FI will apply the regulations in effect on and after October 1, 2002, or July 1, 2003, if applicable, when reviewing the providers' applications for provider-based status. If an application does not contain all the documentation necessary for a determination to be made, the FI may request that the provider submit the additional documentation. Any *determinations* made on such applications can be effective as early as the earliest date that the facility or organization is found to meet the provider-based rules, but not before October 1, 2002. In addition, for periods prior to October 1, 2002, (but not before October 1, 2000), because §404(c) of BIPA states that a facility or organization that seeks a determination of provider-based status on or after October 1, 2000, and before October 1, 2002, shall be treated as having provider-based status for any period *before a determination is* made, CMS will treat the facility as provider-based from the date the application was submitted until the date that CMS makes a provider-based determination. (This is in addition to provider-based status deemed under §404(a) of BIPA.)

F. Provider Education

You must inform the affected provider community of the information outlined in this memorandum within 2 weeks of its receipt by posting portions of this PM relevant to the provider community on your Web site. You should use your list-serv to send notification to providers that important information about the provider-based determination process and requirements is available on your Web site.

Attachment

The *effective date* of this PM is October 1, 2002.

The *implementation date* of this PM is May 1, 2003.

This PM may be discarded April 30, 2004.

Funding is available through the regular budget process for costs required for implementation.

If you have any questions, contact Tzvi Hefter at (410) 786-4487.

SAMPLE ATTESTATION FORMAT

The following is an example of an acceptable format for an attestation of provider-based compliance.

Please note that provider-based determinations in relation to hospitals are not made for the following facilities: ambulatory surgical centers (ASCs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), skilled nursing facilities (SNFs), 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 (subject to §413.65(a)(1)(ii)(G)), facilities other than those operating as parts of CAHs that furnish only physical, occupational, or speech therapy to ambulatory patients (subject to § 413.65(a)(1)(ii)(H)), ESRD facilities, departments of providers that perform functions necessary for the successful operation of the providers but do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid (for example, laundry or medical records departments), ambulances.

(**Note:** As of the date of release of this Program Memorandum, legislation has not been enacted to further extend the moratorium on applying the $1,500 annual cap on physical therapy, occupational therapy, and speech therapy services of providers and suppliers other than hospitals).

Provider-Based Status Attestation Statement

Main provider's Medicare Provider Number: _____
Main provider's name: _____
Main provider's address: _____
Application Contact name and Phone Number_____

Facility/Organization's name: _____
Facility/Organization's **exact** address: _____
(Include bldg. no., suite/room no., etc.) _____
Facility/Organization's Medicare Provider Number, if there is one: _____

Is the facility/organization part of a multi-campus hospital?_____
Is the facility a Federally Qualified Health Center (FQHC)? If so, and if the FQHC meets the criteria at section 413.65(n), it need not attest to its provider-based status. The provider-based rules do not apply to other FQHCs that do not meet the criteria at section 413.65(n), and an attestation should not be submitted.

The facility/organization became provider-based with the main provider on the following date:
_____
(Please indicate if this attestation is adding deleting, or changing previous information—if yes, please make certain to include the effective date.)

Indicate whether the facility/organization is "on campus" or "off campus" (per § 413.65(a)(2)) with the main provider:

1. _____ **On campus** of the main provider (located within 250 yards from the main provider building)

OR

2. _____ **Off campus** of the main provider (located 250 yards or greater from the main provider building, but subject to § 413.65(e)(3))

I certify that I have carefully read the attached sections of the Federal provider-based regulations, before signing this attestation, and that the facility/organization complies with the following requirements to be provider-based to the main provider (initial ONE selection only):

1. _____ The facility/organization is "**on campus**" per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(g), other than those in §413.65(g)(7). If the facility/organization is operated as a joint venture, I certify that the requirements under §413.65(f) have been met. I am aware of, and will comply with, the requirement to maintain documentation of the basis for these attestations (for each regulatory requirement) and to make that documentation available to the Centers for Medicare & Medicaid Services (CMS) and to CMS contractors upon request.

OR

2. _____ The facility/organization is "**off campus**" per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(e) and §413.65(g). If the facility/organization is operated under a management contract/agreement, I certify that the requirements of §413.65(h) have been met. Furthermore, I am submitting along with this attestation to the Centers for Medicare & Medicaid Services (CMS), the documentation showing the basis for these attestations (for each regulatory requirement).

Please complete the following for on campus AND off campus facilities and organizations:

I attest that the facility/organization complies with the following requirements to be provider-based to the main provider (please indicate Yes or No for each requirement):

1. ____ The department of the provider, the remote location of a hospital, or the satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license. If the provider and facility/organization are located in a state having a health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers, the commission or agency has not found that the facility/organization is not part of the provider.

2. ____ The clinical services of the facility or organization seeking provider-based status and the main provider are integrated.

   2a. ____ Professional staff of the facility or organization have clinical privileges at the main provider.

   2b. ____ The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

   2c. ____ The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

2d. ____ Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

2e. ____ Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

2f. ____ Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

3. ____ The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.

4. ____ The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

5. ____ In the case of a hospital outpatient department or a hospital-based entity **(if the facility is not a hospital outpatient department or a hospital-based entity, please record "NA" for "not applicable" and skip to requirements under number 6)**, the facility or organization fulfills the obligation of:

5a. ____ Hospital outpatient departments located either on or off the campus of the hospital that is the main provider comply with the anti-dumping rules in §§489.20(l), (m), (q), and (r) and §489.24 of chapter IV of Title 42.

5b. ____ Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) are billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined under the rules of Part 414 of chapter IV of Title 42.

5c. ____ Hospital outpatient departments comply with all the terms of the hospital's provider agreement.

5d. ____ Physicians who work in hospital outpatient departments or hospital-based entities comply with the non-discrimination provisions in §489.10(b) of chapter IV of Title 42.

5e. ____ Hospital outpatient departments (other than RHCs) treat all Medicare patients, for billing purposes, as hospital outpatients. The departments do not treat some Medicare patients as hospital outpatients and others as physician office patients.

5f. ____ In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at §412.2(c)(5) of chapter IV of Title 42 and at § 413.40(c)(2) of chapter IV of Title 42, respectively. (**Note: If the potential main provider is a CAH, enter "NA" for this item).**

5g. ____ (**Note: This requirement only applies to off campus facilities).** When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, and the treatment is not required to be provided by the antidumping rules in §489.24 of chapter IV of Title 42, the hospital provides written notice to the beneficiary, before the delivery of services, of the amount of the beneficiary's potential financial liability (that is, that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability).

(1)____The notice is on that the beneficiary can read and understand.

(2)____If the exact type and extent of care needed is not known, the hospital furnishes a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he or she would not incur if the facility were not provider-based.

(3)____The hospital furnishes an estimate based on typical or average charges for visits to the facility, but states that the patient's actual liability will depend upon the actual services furnished by the hospital.

(4)____If the beneficiary is unconscious, under great duress, or for any other reason is unable to read a written notice and understand and act on his or her own rights, the notice is provided before the delivery of services, to the beneficiary's authorized representative.

(5)____In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules at § 489.24 of chapter IV of Title 42, the notice is given as soon as possible after the existence of an emergency condition has been ruled out or the emergency condition has been stabilized.

5h. _____ Hospital outpatient departments meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

For off campus facilities, please complete the following:

In addition to the above requirements (numbers 1-5h), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider as an off campus facility (please indicate Yes or No for each requirement):

6. ____ The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

6a. _____ The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.

6b. ____ The main provider and the facility or organization seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.

6c. ____ The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status is subject to common bylaws and operating decisions of the governing body of the provider where it is based.

6d. _____ The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the facility or organization.

7. _____ The reporting relationship between the facility or organization seeking provider-based status and the main provider has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:

7a. ____ The facility or organization is under the direct supervision of the main provider.

7b. ____ The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity--

(1) ____ Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its existing departments; and

(2) ____ Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

7c. ____ The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are (1) contracted out under the same contract agreement; or (2) handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

8. _____ The facility or organization is located within a 35-mile radius of the campus of the potential main provider, except when the requirements in paragraph 8a of this section are met (please check below in the appropriate location if you qualify for the exemption):

8a. ____ The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under §412.106 of chapter IV of Title 42) greater than 11.75 percent or is described in §412.106(c)(2) of chapter IV of Title 42 implementing section 1886(e)(5)(F)(i)(II) of the Act and is:

(1) ____ Owned or operated by a unit of State or local government;

(2) ____ A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(3) ____ A private hospital that has a contract with a State or local government that includes the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare (or medical assistance under a Medicaid State plan).

8b. ____ The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the attestation for provider-based status is filed with CMS, and for each subsequent 12-month period:

(1) ____ At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(2) ____ At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(3) ____ If the facility or organization is unable to meet the criteria in (1) or (2) directly above because it was not in operation during all of the 12-month period described paragraph 8b, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph 8b, accounted for at least 75 percent of the patients served by the main provider.

8c. ____ If the facility or organization is attempting to qualify for provider-based status under this section, then the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

Note: An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area as defined in § 412.62(f)(1)(iii) of chapter IV of Title 42, and has fewer than 50 beds as determined under §412.105(b) of chapter IV of Title 42, is not subject to the criteria in 8a and 8b above.

9. ____ The facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of 1-8 above, but is operated under management contract, meets all of the following criteria **(please respond to 9a - 9d if the facility is operated under a management contract; otherwise record "NA" for "not applicable")**:

9a. ____ The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at Part 414 of chapter IV of Title 42. Other than staff that may be paid under such a Medicare fee schedule, the main provider does not utilize the services of "leased"

employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

9b. ____ The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph 7c above.

9c. ____ The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph 7b above.

9d. ____ The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

For facilities/organizations operated as joint ventures requesting provider-based determinations: In addition to the above requirements (numbers 1-5h for on campus facilities), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider:

10. ____ The facility or organization being attested to as provider-based is a joint venture that fulfills the following requirements:

10a. ____ The facility is partially owned by at least one provider;

10b. ____ The facility is located on the main campus of a provider who is a partial owner;

10c. ____ The facility is provider-based to that one provider whose campus on which the facility organization is located; and

10d. _____ The facility or organization meets all the requirements applicable to all provider-based facilities and organizations in paragraphs 1-5 of this attestation.

*** I certify that the responses in this attestation and information in the documents are accurate, complete, and current as of this date. I acknowledge that the regulations must be continually adhered to. Any material change in the relationship between the facility/organization and the main provider, such as a change of ownership or entry into a new or different management contract, may be reported to CMS. (NOTE: ORIGINAL ink signature must be submitted)**

Signed:_____
(Signature of Officer or Administrator or authorized person)

_____
(PRINT Name of signature)

Title :_____
(Title of authorized person acting on behalf of the provider)

_____
(Direct telephone number)

Date :_____

*** Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years or both. (18 U.S.C. § 1001).**