Medicare Mid-Build Off-Campus Outpatient Departments Exception Audit Results

The Bipartisan Budget Act of 2015 changed the way off-campus provider-based departments bill Medicare for items and services furnished to Medicare patients. Under the law, existing off-campus provider-based departments could continue to be paid as they were before under the Outpatient Prospective Payment System (OPPS). New departments would be paid under the “applicable payment system” (determined by the Centers for Medicare & Medicaid Services (CMS) to be the Physician Fee Schedule). The 21st Century Cures Act gave some providers the ability to claim an exception for the off-campus provider-based department to continue to be paid under OPPS if the department was “mid-build” at the time of the enactment of the Bipartisan Budget Act of 2015.

Through the 21st Century Cures Act, Congress mandated that CMS audit all providers that applied for the exception to ensure their provider-based departments met all the following requirements:

1. The hospital must have filed an attestation within 60 days after the date of enactment of the 21st Century Cures Act, supporting the department in question is provider-based in accordance with 42 CFR 413.65(b)(3).
2. The Parent Provider must have reported the off-campus Provider Based Department by submitting a change to its 855A enrollment form, adding the location.
3. The chief executive officer or chief operating officer of the provider must have submitted a certification prior to 60 days after the date of enactment of the 21st Century Cures Act, stating that the off-campus Provider Based Department meets the definition of mid-build.
4. The provider must have entered into a binding written agreement with an outside, unrelated party for the actual construction of such department before November 2, 2015.

CMS conducted the audits to determine if the providers met the mid-build exception requirements and reviewed the applications along with supporting documentation. CMS worked hard to ensure that the mid-build audits were completed correctly, including implementation of the secondary quality assurance review to ensure the audit determinations were appropriate.

Soon after the reviews were completed, the COVID-19 public health emergency began. CMS is now issuing the determination letters to allow providers to evaluate billing practices, correct any
inaccuracies in claims submissions by identifying overpayments owed to CMS or underpayments due to the provider.

CMS conducted audits of the 334 providers that requested the mid-build exception. Of those, 132 qualified and 202 failed to qualify for the exception.

Providers that failed the mid-build exception audit and have been billing for the services provided by their off-campus provider-based departments under the OPPS, likely have received overpayments. Also, providers that have passed the mid-build exception audit and have not been billing for the services provided by their off-campus provider-based departments under the OPPS, likely have been underpaid.

CMS will issue audit determination letters to all affected providers on January 19, 2021. The letter will provide the final determination on meeting the exception, the appropriate point of contact information, and further instructions.

The 21st Century Cures Act states that the mid-build exception audit determinations are final and may not be appealed.

CMS will afford all providers a total of 240 days to address any overpayments as a result of the audit findings. All affected providers should refer to their audit determination letters for more specific instructions and, upon request, hospitals may be eligible for an Extended Repayment Schedule (ERS) for any overpayments per standard procedure if they meet applicable statutory and regulatory criteria.