	Regulatory Compliance Policy	No. COMP-RCC 4.29
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	PROVIDER-BASED STATUS	Effective Date: 06-30-19
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		Corporate Review Dated: 06-03-19

I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tenet Facility") (collectively, "Tenet").

II. PURPOSE:

The purpose of this policy is to ensure, through the implementation of prudent and reasonable controls, that Tenet Facilities operating hospitals comply with the Medicare provider-based status rules and regulations (as well as other applicable laws and regulations, including the federal Anti-Kickback law and the Stark law) with respect to all facilities they operate or seek to operate as provider-based.

III. DEFINITIONS:

A. "**Provider-Based Entity**" or "**PB Entity**" means an Off-Campus facility or On-Campus entity for which a Tenet Entity seeks provider-based status.

B. "**Off-Campus**" means a facility that does not meet the definition of On-Campus.

C. "**On-Campus**" means an entity located (1) immediately adjacent to the Hospital's main buildings or other areas and structures that are not strictly contiguous to the main buildings but are located within a 250 yard radius of the main building or (2) outside of a 250 yard radius of the main buildings but within the area formally designated in writing by the CMS regional office to be the Hospital's main campus. For noncontiguous buildings, the 250 yard rule requires measurement from the two nearest public entrances of the PB Entity and the Hospital. For purposes of this policy, the term "**On-Campus**" does not include departments, facilities, or entities located within the Hospital's main buildings: such departments, facilities, or entities are not subject to the Provider-Based Rules.

D. "**Hospital**" means the main provider that either creates, maintains, or acquires ownership of another entity to deliver additional health care services under its name, ownership, financial and administrative control and whose provider number must be used by the PB Entity for billing purposes.

E. "**Department of the Hospital**" means a facility or organization that is created maintained, or acquired by a Hospital for the purpose of furnishing health care services of the same type as those furnished by the Hospital under the name, ownership, and financial and administrative control of the Hospital. A department

of a Hospital comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment needed to deliver the services at that facility.

F. **"Excepted Off-Campus PB Entity"** means an Off–Campus PB entity that was billing for covered outpatient department services furnished prior to November 2, 2015, and that have not relocated or changed ownership. Services will be paid under the Outpatient Perspective Payment Systems (OPPS).

G. **"Nonexcepted Off-Campus PB Entity"** means an Off–Campus PB entity that began billing for covered outpatient department services furnished on or after November 2, 2015. Services will be paid under the Medicare Physician Fee Schedule (MPFS).

H. "**Dedicated Emergency Department**" means any department or facility of the Hospital, regardless of whether it is located on or off the main hospital campus, which meets at least one of the following:

1. It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department;

2. It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or

3. During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provided at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis

I. "**Disproportionate Share Hospital**" or "**DSH**" means (1) a hospital or a critical access hospital (CAH) with a disproportionate share adjustment exceeding 11.75% (as may be changed from time to time under Medicare rules) or (2) an urban hospital with more than 300 beds which derived more than 30% of its net inpatient care revenues from state and local government payments for care furnished to indigent patients.

J. "**Community Based Emergency Room**" means a Dedicated Emergency Department of the Hospital that is located off the main hospital campus.

IV. POLICY:

Tenet Facilities must follow the steps set forth in this policy to (1) identify those Tenet Hospitals that are subject to the Medicare provider-based rules and (2) take appropriate steps to ensure compliance with the Medicare provider-based regulations and billing standards as described in this policy and at 42 CFR §413.65, which include licensing, management and administration, patient awareness and medical records requirements.

V. PROCEDURE:

A. Applicability of Provider Based Status

1. If an entity provides services for which there will be a Medicare or Medicaid payment differential depending upon whether the entity is free-standing or provider-based, the entity may only bill for services under a Hospital's provider-number to the extent the entity meets the requirements of the Medicare provider-based status rules, as those rules are set forth in 42 CFR 413.65, as described below. Given the complexity of the provider-based rules, a determination to treat an entity as provider-based should be made in conjunction with the facilities assigned Regulatory Counsel and Reimbursement Director.

2. The Medicare provider-based rules do not apply to the following types of services or facilities and thus, provider-based status is not applicable.

   a. Outpatient departments located within the four walls of the hospital

   b. Ambulatory Surgical Centers

   c. Comprehensive Outpatient Rehabilitation Facilities

   d. Home Health Agencies

   e. Skilled Nursing Facilities

   f. Hospices

   g. Inpatient Rehabilitation Units excluded from the inpatient prospective payment system (PPS) for acute hospital services

   h. Independent Diagnostic Testing Facilities furnishing only services paid under a fee schedule, facilities that furnish only clinical

diagnostic laboratory tests, or facilities that furnish only some combination of these services[1]

i. End Stage Renal Disease (ESRD) facilities (See distinct provider-based status requirements applicable to ESRD facilities codified at 42 C.F.R. Section 413.174)

j. 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)

k. Ambulances

l. Rural health clinics (RHCs) affiliated with hospitals having 50 or more beds.

3. Further, under Medicare's Site-Neutral Payment Polices, outpatient services provided in off-campus hospital locations are no longer be paid as hospital services (i.e., are not reimbursed under OPPS) unless the services are provided:

a. In a Dedicated Emergency Department;

b. In an off-campus provider-based department that was billing for covered outpatient department services furnished prior to November 2, 2015, and that has not relocated or changed ownership; or

c. In a remote location of the hospital (i.e., a separate hospital campus that provides inpatient and outpatient services under the same Medicare provider number as the primary hospital).

Unless a provider-based location meets one of the exceptions above, the off-campus entity would not be reimbursed under OPPS, and therefore, provider-based status generally should not be sought.

B. New Provider Based Entity

[1]The CAH off-campus location regulations at §485.610(e)(2) apply to off-campus distinct part units, as defined at §485.647, to departments that are off-campus, to remote locations of CAHs, as defined at §413.65(a)(2), and, on or after October 1, 2010, to off-campus facilities that furnish only clinical diagnostic laboratory tests operating as parts of CAHs.

1. Given the complexity of the provider-based rules, before making a decision to start a new off-campus provider-based department, the facilities assigned Regulatory Counsel and Reimbursement Director must be consulted and grant approval. The facility must submit a formal review request using the form attached. (Attachment B - New Proposed Off Campus Provider-Based Department Review Request)

C. Operational Requirements for Provider-Based Locations

1. Once an entity has been determined to be provider-based, the PB entity must meet the following operational requirements:

   a. PB Entities located On-Campus must comply with the Emergency Medical Treatment and Active Labor Act (EMTALA).

   b. PB Entities located Off-Campus must comply with EMTALA if they qualify as a Dedicated Emergency Department.

   c. Physician services furnished at the PB Entity (other than Rural Health Clinic (RHC) services) must be billed with the correct site-of-service indicator.

   d. PB Entity must comply with all the terms of the Hospital's provider agreement.

   e. Physicians who work in the PB Entity are obligated to comply with Medicare non-discrimination provisions.

   f. All Medicare patients treated at a PB Entity (other than an RHC) must be treated for billing purposes as hospital outpatients. The PB Entity may not treat some Medicare patients as hospital outpatients and others as physician office patients.

   g. 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 in the Medicare regulations.

   h. Hospital outpatient departments must meet applicable hospital

health and safety rules for Medicare-participating hospitals in 42 CFR Part 482.

2. Coinsurance Notification

When a Medicare beneficiary is treated in an off-campus provider-based entity, and the treatment is not required to be provided by the anti-dumping rules (e.g., EMTALA), 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.[2] See Exhibit A for a template coinsurance notification form.

3. Claim Modifiers

a. PO and PN Modifier:

i. Excepted Off-Campus PB Entities must report the "PO" modifier. The PO modifier only applies to services paid under the OPPS. Accordingly, therapy services that are billed under the MPFS and laboratory tests paid separately through the Clinical Laboratory Fee Schedule should not have the PO modifier applied.

ii. Nonexcepted Off-Campus PB Entities must report the "PN" modifier. The PN modifier will trigger a payment rate under the MPFS. CMS expects the PN modifier to be reported with each nonexcepted item and service, including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

iii. Neither the PO nor the PN modifier is to be reported by the

[2] The notice must be one that the beneficiary can read and understand. 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 was not provider-based. 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 facility. 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. In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping rules of 42 C.F.R. § 489.24, notice, as described in this paragraph, must be given as soon as possible after the existence of any emergency has been ruled out or the emergency condition has been stabilized.

following hospital departments:

- A Dedicated Emergency Department as defined above
- A PB Department that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital

b. ER Modifier:

i. Modifier "ER" is required to be reported in provider-based off-campus emergency departments that meet the definition of a "dedicated emergency department" as defined in 42 Code of Federal Regulations *(*CFR) 489.24 under the Emergency Medical Treatment and Labor Act (EMTALA) regulations.

ii. Hospitals are required to report the modifier ER with every claim line for outpatient hospital services furnished in an off-campus provider-based emergency department.

4. Off-Campus Address

a. The Off-Campus PB entity location address must be reported in the 2310 loop of the 837 institutional claim transaction. The address must exactly match the information on Form CMS-855A, entered into the Provider Enrollment Chain and Ownership System (PECOS).

b. Contact your facility assigned licensing paralegal for information on how the PB entity is entered into the PECOS system. In addition, the licensing paralegals can assist with the addition or removal of a PB entity from PECOS.

D. Changes to an Existing Provider-Based Location

1. Generally, changes to a PB entity, such as relocation to a new off-campus site would result in the facility losing its excepted status, and being subject to the site-neutral payment policy (i.e., cease to be reimbursed as a hospital under OPPS).

2. Off-campus PB entities may only be permitted to relocate temporarily or permanently without loss of excepted status due to extraordinary circumstances outside of the hospital's control, such as natural disasters, significant seismic building codes, or significant public health and public

safety issues.

3. Relocation of a PB entity, or any other change in operations (including relocations) of the PB entity, should only be made in conjunction with a review by Government Programs and Regulatory Counsel.

E. Update To and Verification Of Provider-Based Location(s)

1. The Tenet Master PB Inventory will be maintained on the Billing Compliance www.etenet.com intranet website.

2. On an annual basis, each facility Chief Financial Officer (CFO) will review the Tenet Master Inventory of PB entities and validate that their facility inventory is accurately represented.

   a. The CFO will validate their facility's inventory and notate any inaccuracies within the comments field on the Tenet Master Inventory.

   b. In addition, if at any time the CFO becomes aware of a significant change to a PB location, they should contact the licensing paralegal, the facilities Regulatory Counsel and Reimbursement Director.

3. Any changes to an existing or new PB location shall be entered upon the Tenet Master PB Inventory by the licensing paralegal.

F. Auditing and Monitoring

Tenet's Audit Services Department will audit adherence to this policy in its routine audits.

G. Responsible Person

Each Tenet Facility CEO and CFO are responsible for ensuring that all individuals adhere to the requirements of this policy, that these procedures are implemented and followed at the Tenet Facility, and that instances of noncompliance with this policy are reported to the Compliance Officer.

H. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- 42 CFR §413.65
- CMS Program Memorandum A-03-030, "Provider-Based Status on or After October 1, 2002."
- CMS MLN Matters Number: MM9930 Effective January 1, 2017 - January 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- CMS MLN Matters Number: SE19007 from March 26, 2019 - Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations
- CMS Off-Campus Provider Based Department "PO" Modifier Frequently Asked Questions
- CMS MLN Matter Number: MM11099 January 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)

VII. ATTACHMENTS:

- Attachment A– Off-Campus Medicare Outpatient Coinsurance Notice
- Attachment B - New Proposed Off Campus Provider-Based Department Review