



Provider-Based Status: Does Your Facility Qualify?

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This article is intended to summarize the answers to many of the common questions that health care providers ask about entities that are known as “provider-based”.

What is provider-based status?

Provider-based status merely means that there is an established and specific relationship between a hospital and another facility or provider of health care services, such that the other facility or provider is considered a subordinate part of the main hospital provider. CMS has issued regulations defining the requirements for provider-based departments and entities.

Why does provider-based status matter?

A determination that a health care provider is “provider-based” impacts reimbursement and coverage. In terms of reimbursement, a provider-based entity is considered “part of the hospital”. Generally, a facility that is “provider-based” is paid under the Hospital Outpatient Prospective Payment System (“OPPS”), rather than under the physician fee schedule. This means that the provider-based entity is generally paid a “technical” component (also referred to as a “facility fee”) in addition to the physician’s professional fee. Overall, reimbursement is higher for provider-based entities than would otherwise be payable under the physician fee schedule.

In terms of coverage, certain services will be covered by Medicare only if the provider is in a hospital setting. For example, CMS reimburses certain outpatient therapeutic services only if those services are furnished in a hospital or a provider-based entity.

What standards must be met in order to be considered provider-based?

The CMS regulations are detailed and complex, but the following requirements must be satisfied:

- Licensure under the same license as the main hospital provider.
- Clinical integration with the main provider, in areas such as privileges, monitoring, oversight, medical directorship, medical staff committees, medical records, and inpatient and outpatient services.
- Financial integration with the main provider, including shared income and expenses, and appropriate treatment on cost reports.
- Public awareness, which means being held out to the public and other payers as part of the main provider, including issues such as naming, advertisement, websites, patient registration forms, letterhead, and billing consistent to all Medicare patients (i.e., all

Medicare patients must be billed a facility charge. The provider-based entity may bill other payers in whatever manner is appropriate under those payers' rules).

- If the provider-based facility is off the main hospital campus, additional standards relating to ownership, control, administration, supervision, and location in the immediate vicinity must be satisfied.

Can a provider-based entity be operated as a joint venture or under a management contract?

A joint venture that is partially owned by the main hospital provider, must be located on the main campus of a hospital owner to which it is "provider-based", and meet all other provider-based requirements.

Management contracts for on-campus sites are permissible. Locations off the hospital campus which are operated under management contracts must meet additional requirements related to employment of staff, administrative integration with the hospital, hospital control over operations, and compliance with hospital policies.

Does CMS need to approve provider-based status?

The formal approval by CMS of provider-based status is not required. However, CMS will consider applications of entities and approve or reject these applications. Providers who bill a facility fee without seeking approval do so at their own risk, because CMS could undertake retrospective recoveries if CMS later determines that a facility is not provider-based.

Billing as a provider-based entity certainly allows higher reimbursement. The requirements for being considered provider-based are significant, and should be carefully considered prior to billing in that fashion.

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