



## **Defining Medicare's Provider-Based Medical Clinic**

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Hospitals often purchase standalone, healthcare entities such as physician practices and nursing facilities. Medicare affords hospitals the license to account for these remote entities as part of the hospital. This arrangement is called "provider-based".

Besides being owned by a hospital, the entity qualifies for provider-based status if it operates in any one of the following four roles of subordinate facilities:

- **Provider-Based Entity can involve practices from** a rural health clinic (RHC) to a federally qualified health center (FQHC), operating under the name, ownership and control of the main provider, that has been created or acquired in order to furnish licensed or certified health services in its own right.
- **Department of a Provider can be a** facility, organization or physician office, operating under the name, ownership and control of the main provider, that has been created or acquired in order to furnish similar services as those of the main provider. Operated only as part of the parent, a department of a provider may not be separately licensed or Medicare certified.
- **Remote Location of a Hospital can be a facility or organization, operating** under the name, ownership and control of the main hospital that has been **created or acquired** to furnish inpatient hospital services without separate licensing or certification.
- **Satellite Facilities can be a** hospital section or unit that provides services in a building used by another hospital or on the same campus as a building used by another hospital.

Currently, Medicare demands proof of the following provider-based requirements for both on-campus and off-campus facilities:

- Licensure
- Clinical Services
- Financial Integration
- Public Awareness
- Obligations of hospital outpatient departments and hospital-based entities
- Joint Ventures

Additional provider-based regulations to be satisfied by off-campus facilities include:

- Operation under the ownership and control of the main provider
- Dependent (?)Administration and Supervision
- Distinct Location
- Management Contracts between main hospital and provider-based entity.

Once Medicare grants provider-based status, hospitals can bill for both the physician and hospital outpatient services in two separate charges. This is called a dual billing structure. Often, clinics do not dual bill for services rendered in physicians' offices. Instead, patients receive only one charge that combines both physician and overhead expenses.

The dual billing structure, however, includes the following fees:

- A facility charge covers staff (excluding physicians, PA, NP) and overhead and is billed under the hospital provider number on a UB form.
- A professional fee for clinic physician services is billed on a CMS 1500 form, indicating the site of service as “Hospital” (22). If the professional fee falls under critical access hospital (CAH), then the physician fees for Medicare would be billed on the hospital UB form.

Medicare reimbursement eligibility under dual billing requires that bills are separated into the two respective components. Consider the professional component as the portion identified with a -26 modifier and the facility component as the portion identified with a -TC modifier. Medicaid reimbursement for these fees varies by state.

The financial advantage of the provider-based clinic designation can be substantial. Because of stringent requirements to the existing and proposed regulations regarding provider-based status, hospitals should evaluate and anticipate their readiness for such status so they can allocate enough time to make necessary operational changes and submit all necessary documentation. Although examining regulations and determining costs of receiving provider-based status can be challenging, a careful analysis of the clinic operations against the regulatory requirements usually is well worth the effort. Many large hospitals have discovered the outcome of provider-based status determinations with respect to clinic systems can result in annual, six-figure, and revenue gains. By performing prompt analysis now, hospitals can avoid failing to achieve provider-based status because of technical errors or correctable deviations from the regulatory requirements.

In addition to the potential reimbursement windfall, an additional advantage of provider-based clinics is the ability to integrate and coordinate patient care between physicians and hospital, thus allowing for higher quality resources and patient satisfaction. A noted disadvantage involves the monetary and management structure of ambulatory clinics.

When evaluating the implementation of provider-based status, one has to look at the overall financial advantage as well as the quality of patient care that can be provided through the integrated operations of clinic and hospital. When considering a conversion from being a standalone clinic to becoming part of a larger organization, all aspects of finance, operations, management, patient care and regulatory requirements should be evaluated to determine whether provider-based status makes sense for an organization.

If you would like more information on ambulatory issues VCS can help. Please contact us at 610.444.1233 or [vcs@getvitalized.com](mailto:vcs@getvitalized.com). Additional information resides on our website, [www.getvitalized.com](http://www.getvitalized.com).