Provider Based Billing

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Disclaimer

Information contained in these materials, including all discussion, is not intended to be legal or business advice. The laws and regulations regarding billing and coding are open to interpretation. It is your responsibility to ensure that coding and billing guidelines are being followed and to seek assistance from outside experts on application of those guidelines specific to your circumstances.
Definitions

Provider Based Care benefits patients as all departments of the hospital are subject to strict quality standards and are monitored by The Joint Commission, an independent, not-for-profit organization that accredits and certifies health care organizations and programs throughout United States.

Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting certain performance standards.

Provider-Based Billing refers to the process for billing for services rendered in a hospital outpatient clinic or location. This is an industry standard model of practice for large, integrated delivery systems involved in patient care.
Provider Based Billing (PBB)

HealthCare Financing Administration (HCFA)
Transmittal No. A-99-24 Date May 1999
Original Publication: A-98-15 Date May 1998

“Provider Based” is an outgrowth of the Medicare cost reimbursement system

It’s main purpose is to accommodate the allocation of costs where there is more than one type of provider activity taking place within the same facility or organization

Appropriate allocation often results in increased Medicare reimbursement
Reimbursement Advantages

Provider Based Billing allows for reallocation of cost to a hospital facility resulting in increased reimbursement

For example reimbursement for 99214 in 2014

Clinic: $104.36

Provider Based Entity
Professional: $ 76.64
Facility: $ 101.27
Total $177.91
Reimbursement Advantages

Destruction of Actinic Keratosis (CPT 17000)

<table>
<thead>
<tr>
<th>Category</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Clinic:</td>
<td>$64.40</td>
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<tr>
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</tr>
<tr>
<td>Professional</td>
<td>$61.74</td>
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<tr>
<td>Facility</td>
<td>$116.85</td>
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<tr>
<td>TOTAL</td>
<td>$178.59</td>
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</table>
Reimbursement Advantages

Arthrocentesis, aspiration or injection, major joint (20610)

Clinic: $58.45

Provider Based Entity
Professional $45.11
Facility $221.89
TOTAL $267.00
Reimbursement Advantages

Laryngoscopy, flexible, fiberoptic, diagnostic (31575)

Clinic: $111.57

Provider Based Entity
Professional $75.30
Facility $140.13
TOTAL $215.43
# Reimbursement Advantages

Anoscopy, diagnostic, (46600)

<table>
<thead>
<tr>
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<tr>
<td>Professional</td>
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<td>Facility</td>
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<td><strong>TOTAL</strong></td>
<td>$130.43</td>
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Reimbursement Advantages

Measurement of post voiding residual urine (51798)

<table>
<thead>
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<th>$18.20</th>
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<tbody>
<tr>
<td>Provider Based Entity</td>
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<tr>
<td>Professional</td>
<td>$18.20</td>
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<tr>
<td>Facility</td>
<td>$90.42</td>
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<td><strong>TOTAL</strong></td>
<td><strong>$188.62</strong></td>
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Reimbursement Advantages

Spinal puncture, lumbar diagnostic (62270)

<table>
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<tr>
<td><strong>Provider Based Entity</strong></td>
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<td>Professional</td>
<td>$76.55</td>
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<tr>
<td>Facility</td>
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<td><strong>TOTAL</strong></td>
<td><strong>$656.84</strong></td>
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</table>
Reimbursement Advantages

Annual wellness visit, subsequent (G0439)

Clinic: $112.57

Provider Based Entity
Professional: $112.57
Facility: $0.00
TOTAL $112.57
Reimbursement Disadvantages

Medicare beneficiaries seen in provider based locations are subject to an increased financial liability:

• The beneficiary (or their supplemental insurance) pays the usual deductible and co-insurance for physician services

• The beneficiary (or their supplemental insurance) is also responsible for a facility deductible and co-insurance
Provider Based Requirements

Entire listing of requirements can be found in the Code of Federal Regulations, title 42 CFR 413.65:

• **Licensure**
  • Provider Based Entity is operating under the same license as the main hospital except when state requirements mandate a separate license

• **Clinical Services Integration**
  • Professional staff must have clinical privileges at the main provider
  • Medical director(s) of the provider based entity maintain a reporting relationship with the Chief Medical Officer of the hospital
  • Medical records are integrated with those of the hospital
Provider Based Requirements

• **Financial Integration**
  • Financial operations of the provider based entity are fully integrated with the main hospital
  • Costs are reported in a cost center of the main hospital
  • Financial status of the provider based entity is incorporated and readily identified in the main hospital’s financial reporting

• **Public Awareness**
  • Patients must be aware they are entering part of the main hospital and that they will be billed accordingly
Provider Based Requirements

- **Obligations of Hospital Based Entities**
  - Hospital outpatient departments must comply with Medicare antidumping rules
  - Professional services must be filed with the correct place of service indicator (hospital outpatient)
  - Payment for services are subject to the 72-hour rule (PPS hospitals) or the 24-hour rule (PPS exempt hospitals)
  - Provider based departments must meet all applicable health and safety rules for Medicare participating hospitals
Provider Based Requirements

• **Location**
  - Must be located on the main campus (within 250 yards of the main hospital) if billing starts **on/after 11/2/2015**
  - Must be located within a 35 mile radius of the main hospital if billing started **prior to 11/2/2015**
    - Off campus billing processed 1-1-2016 (not date of service) must be submitted with place of service 19 on professional claims. Modifier PO must be added to facility claims
  - Must be able to demonstrate that the provider based entity serves the same patient population as the main hospital
Decision Making

Making the decision to move to provider based care, and ultimately provider based billing, cannot be dependent on reimbursement alone:

- Is this decision good for our patients?
- Is this decision good for our organization?
- Will the decision be supported organization wide?
- Can we meet the necessary Joint Commission requirements?
- Do we meet the provider based requirements?
- Can our billing software successfully handle this change?
- Can we meet the financial reporting requirements?
- Can we successfully notify our patients of this change?
Identify what reimbursements will be increased by submitting both a professional and facility charge:

- Medicare
- Medicare Advantage Plans
- Medical Assistance
- Contracted Payers
- Commercial Payers
- Self-Pay

Check with your contracts to determine reimbursement differences

Notify your contracts with your final decision
Determine what locations qualify for provider based billing (i.e. on the main campus, within a 35 mile radius, reporting structure in place, etc.)

Within the identified locations, determine what departments will be included in provider based billing

• Service Line
• Provider Type
• Reimbursement Issues

Implement appropriate contracts to ensure the space and costs are allocated to the hospital
Use the Medicare Database (PC/TC indicator) to determine what codes need facility fees:

- Physician Services Code: Split professional and facility
- Diagnostic Tests for Radiology Services: Split 26/TC modifier
- Professional Component Only Code: Professional service only
- Technical Component Only Code: Technical service only
Why.....

Ensure that all staff is educated on why this change is taking place

• Improved patient care
• National standard for integrated health care facilities
• Ability to assist the organization in meeting it’s financial goals
When....

Determine a timeline

• Legal Contracts
• Joint Commission Requirements
• Insurance Company Notifications
• Provider Enrollment Forms
• Electronic Fund Transfer Forms
• Signage
• Patient Education
• System Build

Moving to Provider Based is a big decision with lots of work involved. Give yourself plenty of time to ensure success
Create an integrated team to ensure all requirements are met

- Patient Care
- Legal
- Facilities
- Human Resources
- Billing
- Finance
- Compliance
- Organization Leadership
- Marketing
How....

• Create a working document and ensure all updates are recorded
  • Share directory
• Meet regularly
• Define the decision making process
• Educate at every opportunity
  • Patients
  • Staff
  • Create talking points and elevator speeches
• Make sure everyone is on the same page
  • Decision needs to be supported at all levels, all the time
• Ensure all policies and procedures are completed
Impact to the Revenue Cycle

Provider based billing affects all areas of the Revenue Cycle. Organizations moving in this direction need to be prepared for changes in:

- Registration
- Charge Capture
- Coding
- Billing
- Payment
- Follow-Up
- Self-Pay
Registration....

Understand what registration forms are required for hospital outpatients:

- Authorization for treatment
- Notice of increased financial liability
- Medicare Secondary Payer
- Patient Rights and Responsibilities

Create a process to ensure collection of necessary signatures and proof of form distribution
Charge Capture.....

Ensure the system is built to follow the process defined by the implementation team:

- Where do professional charges post?
- Where do facility charges post?
- Do providers need to change any charge capture processes?
- Are the fee schedules/chargemaster set up correctly?
- Will all patients be billed the same total amount?
- Are the appropriate revenue codes for facility services assigned?
Coding....

Ensure the coding staff understand their new work:

• Where will they look for charges?
• How do they make changes?
• Do they need to pay attention to fees?
• What if something is posted incorrectly?
• Where can they escalate questions to?
  • Keep the chain of command intact so problems can be tracked.
• Do their production standards change?
  • How will they be measured?
• Are individual meetings needed?
Billing....

What should billing staff look for?

• Consecutive account issues
• Increased claim edits
• Payer rejects specific to provider based billing
• Denials
  • Provider eligibility issues
• Unexpected changes in payment
• Patient complaints
Payment....

Payment staff should escalate the following issues immediately:

• Noticeable changes in payment frequency
• Zero payments related to provider based departments/providers
• Payer phone calls for additional information regarding the PBB change
Follow-Up....

The following should be monitored, trended and escalated as needed:

- All denials related to provider based billing
  - Provider eligibility issues
- Unexpected changes in payment
- Payer concerns
- Patient complaints
Self-Pay....

Monitor patient concerns over self-pay balances:

• Ensure staff with patient contact understand the PBB billing rules and what they should expect to see
  • Can they explain it to the patient?
• Escalate any patient concern trends
• Escalate any unexpected findings
Hidden Identified Costs

• Joint Commission Accreditation
• Hospital rules apply, i.e. order requirements
• 304b Drugs thru pharmacy (pyxis vs. additional staff)
• Patient has two charges, professional and facility
• Signage
• 72-hour rule reporting
• Accounting/Finance issues
• Medical record documentation changes
• Provider enrollments
• Internal contracts
• Staff Education
• Initial increase in AR days
Implementation

The work does not end at go-live. Part of the implementation plan should be:

• Monitoring
• Measuring
• Tweaking
• Recording
• Reporting
Monitoring...

Monitor the entire revenue cycle for unexpected outcomes and educate staff on how to escalate findings

• Keep the implementation team in the loop
• Is there an increase in patient complaints/concerns?
• Watch denials and monitor trends
Measuring...

Create a process to ensure what you have done is working:

- Are you capturing the same gross revenue as you did before go-live?
- Is reimbursement as expected?
  - Increased Medicare reimbursement
- Are there any barriers to being successful?
- Monitor the regulations for changes!!
Tweaking...

Expect the unexpected and have a change process in place:

• How can issues be escalated?
• Where should issues be escalated?
• How will the changes be recorded?
  • Do policies/workflows need to be updated?
• How will the implementation team be notified?
Reporting...

Be prepared to be transparent in all reporting:

• Not sharing identified issues will likely come back to you
  • This type of program implementation affects many aspects of the organization and issues are expected to occur
    • Credibility comes with how the issues are handled
• Report all issues without assigning blame
• Be prepared for questions on how the issue will be resolved
  • If a solution is not readily available, report that
• Success will be measured as a team...not an individual
Resources

Although the Internet will provide many resources on provider based billing, it is safest to follow CMS (Centers for Medicare and Medicaid Services) published guidance.

When using industry provider based billing websites, try and tie the information back to Medicare publications.

Ask for assistance when needed:
- Compliance
- Consultants
- Peers

Confirm all decisions in writing with the implementation team.
Resources

• Sign-up for carrier list serves and monitor proposed and finalized changes
• Monitor information from healthcare consultants
• Create a peer listing
What’s Next

Updated place of service code
• 19 “Off Campus- Outpatient Hospital”
• 22 “On Campus- Outpatient Hospital) goes live 1/1/16

Expect continued fee schedule changes included additional bundling of procedures

CCI and black box edits continue to be updated
Resources

Resources used within this presentation are noted within each applicable slide

Other resources include:


• Modern Health Care A.M.  http://www.modernhealthcare.com/section/subscriptions

• Ober | Kaler Payment Matters  http://www.ober.com/publications/subscribe

• CMS  http://www.cms.gov/About-CMS/Agency-Information/Aboutwebsite/EmailUpdates.html

• Becker’s Hospital Review  http://visitor.r20.constantcontact.com/manage/optin/ea?v=001Mro14wcDZcCXd5baXjRiMg%3D%3D

• King and Spalding submit contact information to  healthcare@kslaw.com

• Wisconsin Health News  http://wisconsinhealthnews.com/subscribe  This is a paid subscription but you can get a free trial.

• Strategic Health Care  www.strategichealthcare.net

• American Hospital Association AHA News Now  http://www.ahанews.com/ahанews/jsp/getnewsnow.jsp
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