2017 Rural Health Clinic Workshop

Maintaining RHC Compliance

October 18, 2017

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AGENDA

- RHC Overview
- Physical Plant and Environment
- Organizational Structure
- Staffing and Staff Responsibilities
- Provision of Services
- Program Evaluation
- Survey Compliance Resources
- Emergency Preparedness
- Billing Compliance
- Provider-Based Status

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RHC Overview

What Is an RHC?

RHC certification is a designation from the Centers for Medicare & Medicaid Services (CMS) to clinics providing primary care in certain rural, underserved areas, which provides an alternative, cost-based reimbursement system for treating Medicare and Medicaid beneficiaries.

RHC Overview

How Are RHCs Paid?

RHCs are paid a flat rate for each *face-to-face encounter* based on the anticipated average cost for direct and supporting services (including allocated costs), with a reconciliation of costs for Medicare services (i.e., cost report) occurring at the end of the fiscal year.

RHC Overview

Cost-based reimbursement is determined on the average cost per visit. A visit is defined as a medically necessary face-to-face encounter between a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker and a patient.

In general, if there is no "visit," there is no RHC payment (exceptions for flu/pneumo vaccines).

RHC Overview

General Requirements for RHC Certification

- Located in a rural area
- Current underserved designation
- Primarily outpatient primary care services
- Midlevel practitioner at least 50% of time clinic is open
  - At least one midlevel practitioner is employed
- Certain lab services must be able to be performed

Physical Plant and Environment

42 CFR 491.6

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Physical Plant and Environment (42 CFR 491.6)

Physical Plant Safety

- To insure the safety of patients, personnel, and the public, the physical plant should be maintained consistent with appropriate state and local building, fire, and safety codes. Reports prepared by state and local personnel responsible for ensuring that the appropriate codes are met should be available for review.
- Determine whether the clinic has safe access and is free from hazarc that may affect the safety of patier personnel, and the public.

Physical Plant and Environment (42 CFR 491.6)

Preventive Maintenance

- A program of preventive maintenance should be followed by the clinic. This includes inspection of all clinic equipment at least yearly, or as the type, use, and condition of equipment dictates; the safe storage of drugs and biologicals (see 42 CFR 491.6(b)(2)); and inspection of the facility to ensure that services are rendered in a clean and orderly environment. Inspection schedules and reports should be available for review by the surveyor.

Organizational Structure

42 CFR 491.7

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Organizational Structure (42 CFR 491.7)

Basic Requirements

- Ascertain that the clinic is under the medical direction of a physician(s), has a staff that meets the requirements of § 491.8, and has adequate written material covering organization policies, including lines of authority and responsibilities.

Organizational Structure (42 CFR 491.7)

Written Policies

- Written policies should consist of both administrative and patient care policies. Patient care policies are discussed under 42 CFR 491.9(b). In addition to including lines of authority and responsibilities, administrative policies may cover topics such as personnel, fiscal, purchasing, and maintenance of building and equipment. Topics covered by written policies may have been influenced by requirements of the founders of the clinic, as well as agencies that have participated in supporting the clinic's operation.

Organizational Structure (42 CFR 491.7)

Disclosure of Names and Addresses

- The clinic discloses names and addresses of the owner, person responsible for directing the clinic's operation, and physician(s) responsible for medical direction.
- Any change in ownership or physician(s) responsible for the clinic's medical direction requires prompt notice to the RO. Neither of these changes requires resurvey or recertification if the change can otherwise be adequately verified. Notice of any change in the physician(s) responsible for providing the clinic's medical direction should include evidence that the physician(s) is licensed to practice in the state.

Staffing and Staff Responsibilities

42 CFR 491.8

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Staffing and Staff Responsibilities (42 CFR 491.8)

Staffing

- The clinic or center has a health care staff that includes one or more physicians. Rural health clinic staffs must also include one or more PAs or NPs.
- A physician, NP, PA, nurse-midwife, clinical social worker, or clinical psychologist is available to furnish patient care services at all times the clinic or center operates. In addition, for rural health clinics, a NP or a PA is available to furnish patient care services at least 50% of the time the clinic operates.

Staffing and Staff Responsibilities (42 CFR 491.8)

Physician's assistant and the nurse practitioner responsibilities

- Participate in the development, execution, and periodic review of the written policies governing the services the clinic furnishes;
- Provide services in accordance with those policies;
- Arrange for, or refer patients to, needed services that cannot be provided at the clinic;
- Ensure that adequate patient health records are maintained and transferred as required when patients are referred; and
- Participate with a physician in a periodic review of the patient's

Staffing and Staff Responsibilities (42 CFR 491.8)

Physician responsibilities (DO/MD)

- Provides medical director for the clinic's activities and consultation for and medical supervision of the health care staff.
- In conjunction with the PA and/or NP member(s), the physician participates in developing, executing, and periodically reviewing the clinic's written policies and the services provided to federal program patients.
- Periodically reviews the clinic's or center's patient records, provides medical orders, and provides medical care services to the patients of the clinic or center.

Provision of Services

42 CFR 491.9

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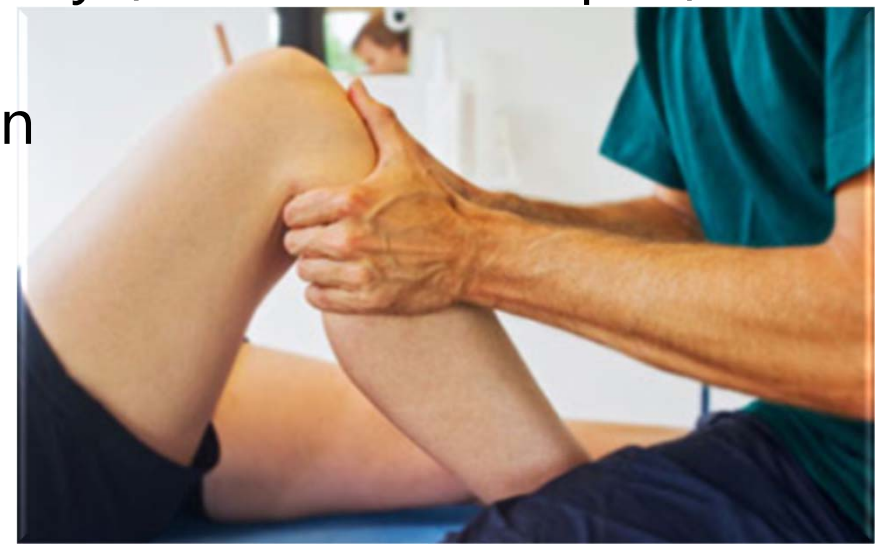
Provision of Services (42 CFR 491.9)

Providing Rural Health Clinic Services

- The law describes an RHC as a facility primarily engaged in providing RHC services as defined in this subpart. Under this definition, a facility may provide services in addition to RHC services, usually related health care services such as the "other ambulatory services" covered by Medicaid state plans. Certification as an RHC applies to the facility as a whole and the total operating schedule of the facility (the hours it is open) is considered when determining if the facility is primarily engaged in providing RHC services.



Provision of Services (42 CFR 491.9)

Providing Rural Health Clinic Services

- If on-site observation of services provided and discussion with the staff indicate that the majority of the services provided by the clinic are primary medical care (treatment of acute or chronic medical problems which usually bring a patient to a physician's office), then the clinic may satisfy the "primarily engaged" requirement providing that RHC services are offered at least 51% of the total operating schedule.

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Provision of Services (42 CFR 491.9)

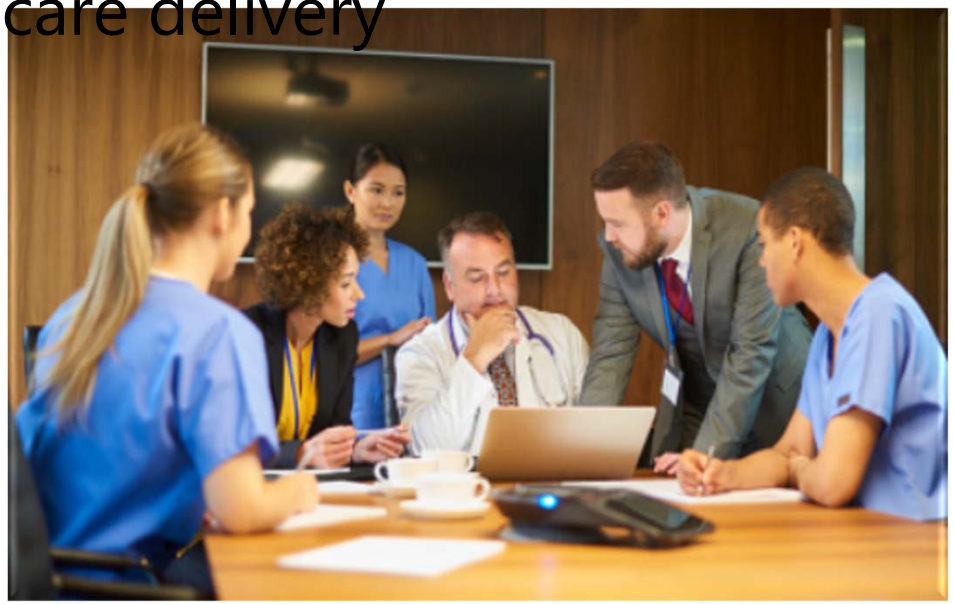
Patient Care Policies Requirements

- Review the clinic's policies and ascertain who developed them . . . it is necessary to ascertain that the current physician member(s) and the NP, certified nurse-midwife, and/or PA member(s) of the staff have an in-depth knowledge of the policies and have had the opportunity to discuss them, adopt them as is, or make any agreed-to written changes in them.

Provision of Services (42 CFR 491.9)

Patient Care Policies Requirements

- In some cases, the clinic may involve health care professionals from a hospital with which the clinic has an agreement for patient referral. In any event, at lease one member of the group of professionals may not be a member of the clinic's staff. Professionals who are not directly related to health care delivery (attorneys, community planners, etc.) are potentially useful.



Provision of Services (42 CFR 491.9)

Patient Care Policies Requirements

- The requirements concerning written policies address four areas:
  1) Description of Services
     - Directly and through arrangement
     - For example, taking complete medical histories, performing complete physical examinations, assessments of health status, routine lab tests, diagnosis and treatment for common acute and chronic health problems and medical conditions, immunization programs, family planning, complete dental care, emergency medical care.

Provision of Services (42 CFR 491.9)

Patient Care Policies Requirements

- The requirements concerning written policies address four areas:

  2) Guidelines for Medical Management

     – For example, protocols, medical directives, criteria for diagnosing and treating conditions.

Provision of Services (42 CFR 491.9)

Patient Care Policies Requirements

- The requirements concerning written policies address four areas:

  3) Drugs and Biologicals
     - Storage of drugs and biologicals
     - Dealing with outdated drugs
     - Prescribing and dispensing

Provision of Services (42 CFR 491.9)

Patient Care Policies Requirements

- The requirements concerning written policies address four areas:

  4) Review of Policies

     – The group of professional personnel is responsible for an annual review of patient care policies.

Provision of Services (42 CFR 491.9)

Direct Services

- The purpose of the Rural Health Clinic Services Act is primarily to make available outpatient or ambulatory care of the nature typically provided in a physician's office or outpatient clinic and the like. The regulations specify the services that must be made available by the clinic, including specified types of diagnostic examination, laboratory services, and emergency treatments.
- The clinic provides medical emergency procedures as a first response to common life-threatening injuries and acute illness and has available the drugs and biologicals commonly used in lifesaving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids.

Provision of Services (42 CFR 491.9)

Direct Services

- Ability to perform (furnish) six basic lab tests:
  - Chemical examinations of urine
  - Hemoglobin or hematocrit
  - Blood sugar
  - Examination of stool specimens
  - Pregnancy tests
  - Primary culturing for transmittal to a certified laboratory

Program Evaluation

42 CFR 491.11

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Program Evaluation (42 CFR 491.11)

- An evaluation of a clinic's total operation including the overall organization, administration, policies and procedures covering personnel, fiscal, and patient care areas must be done at least annually. This evaluation may be done by the clinic, the group of professional personnel required under 42 CFR 491.9(b)(2), or through arrangement with oth

Program Evaluation (42 CFR 491.11)

The evaluation includes review of:

- The utilization of clinic or center services, including at least the number of patients served and the volume of services.
- A representative sample of both active and closed clinical records.
- The clinic's or center's health care policies.

Program Evaluation (42 CFR 491.11)

The purpose of the evaluation is to determine whether:

- The utilization of services was appropriate.
- The established policies were followed.
- Any changes are needed.

The clinic or center staff considers the findings of the evaluation and takes corrective action if necessary.

Program Evaluation (42 CFR 491.11)

- If the facility has been in operation for at least a year at the time of the initial survey and has not had an evaluation of its total program, report this as a deficiency. It is incorrect to consider this requirement as not applicable (N/A) in this case.
- A facility operating less than a year or in the start-up phase may not have done a program evaluation. However, the clinic should have a written plan that specifies who is to do the evaluation, when and how it is to be done, and what will be covered in the evaluation.

Survey Compliance Resources

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Resources

- Rural Health Clinic Survey Report (CMS 30)
  - e.com/Forms/CatalogView/Healthcare/Centers%20for%20Medicare%20and%20Medicaid%20Services%20(CMS)/Reports/CMS30.pdf
- Oregon RHC Pre-Inspection Tool
  - http://formunivershttp://www.ohsu.edu/xd/outreach/oregon-rural-health/clinics/rhc-ta-resources/upload/RHC-Pre-Inspection-Practice-Tool.pdf
- State Operations Manual (SOM Appendix G)
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_g_rhc.pdf
- 42 CFR 491
  - http://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol5/CFR-2011-title42-vol5-part491

Emergency Preparedness

42 CFR 491.12

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Emergency Preparedness (42 CFR 491.12)

- CMS released final rule on September 16, 2016
- Implementation date of November 15, 2017
- CMS estimates the cost to implement the new emergency preparedness rules at over $6,000 per RHC
- Must be in compliance with emergency preparedness regulations to participate in Medicare or Medicaid
- Removed requirements on emergency preparedness found at § 491.6(c)
- Replaced with new requirements at § 491.12

Emergency Plan (42 CFR 491.12 (a))

Emergency Preparedness – November 15, 2017

- "All hazards approach" focuses on the preparedness for a full range of emergencies.
  - Natural disasters
  - Man-made disasters
  - Facility-based disasters
- A "Hazard Vulnerability Assessment" (HVA) can be used to identify and order risks by degree of magnitude for each RHC



Emergency Preparedness (42 CFR 491.12)

Emergencies may include but are not limited to . . .

- Natural disasters
  - Pandemic
  - Hurricanes/Tornados
  - Fires/Earthquakes
- Man-made disasters
  - Chemical spills
  - Nuclear or biological terrorist attack
  - Active shooter/Terrorist
- Facility-based disasters
  - Power outages, equipment and utility failures
  - Interruptions in communication, including cyber attacks
  - Interruptions to the supply of essential resources, such as water, food, fuel

Emergency Preparedness (42 CFR 491.12)

Out with the old . . .

- § 491.6(c)
  - The clinic assures the safety of patients in case of non-medical emergencies by:
    - Training staff in handling emergencies,
    - Placing exit signs in appropriate locations, and
    - Taking other appropriate measures that are consistent with the particular conditions of the area in which the clinic is located.

Emergency Preparedness (42 CFR 491.12)

In with the new . . .

- § 491.12(a) requires the development of an emergency preparedness plan.
- § 491.12(b) requires clinic to develop policies and procedures resulting from the emergency plan.
- § 491.12(c) requires clinic to develop and maintain an emergency preparedness communication plan.
- § 491.12(d) requires clinic to develop and maintain a training and testing program.
- § 491.12(e) allows the clinic to participate in an integrated system-wide emergency preparedness plan.

Emergency Plan (42 CFR 491.12(a))

Preparing the Emergency Plan

- Include the administrator, physician, midlevel, and a registered nurse on the team to assess the risk of the RHC
- Complete a "Hazard Vulnerability Assessment" (HVA) and include strategies for addressing emergencies with the highest risk
- Create an authority succession plan for delegation of authority during an emergency
- Have a process for cooperation with local, state, and federal emergency preparedness officials
- **Emergency plans must be updated annually**

Policies and Procedures (42 CFR 491.12(b))

Develop Policies and Procedures to Include:

- Evacuation and staff responsibilities
- Placement of exit signs
- Shelter and sustenance for people who remain in the facility
- Use of volunteers to address surge needs
- Continuity of operations for essential functions and systems
- Preservation of medical documentation

Communication Plan (42 CFR 491.12(c))

Emergency Preparedness Communication Plan

- Comply with federal and state laws
- Include contact information (phone number and alternate)
- Include primary and alternate means of communicating with staff and local emergency agencies
- Provide information about operating status and location of patients
- Indicate needs and ability to provide assistance
- Communication plans must be updated annually

Communication Plan (42 CFR 491.12(d))

Training and Testing

- Develop and maintain a training and testing program based on:
  - Risk assessment
  - Emergency plan
  - Communication plan
- Train new staff and existing staff at least annually
- Participate in one full scale community-based exercise annually
- Participate in second full scale or table top exercise annually
- Document drills and analyze performance

Communication Plan (42 CFR 491.12(e))

Integrated Healthcare Systems

- Two options:
  - Develop an emergency preparedness plan as an entire health system

    (1) Demonstrate each certified facility actively participated

    (2) Take into account each facility's unique circumstances

    (3) Demonstrate each facility is capable of using the integrated EP plan

    (*) If one certified facility is noncompliant, the entire system is noncompliant
  - Develop a plan independently as an RHC

Resources

- Emergency Preparedness Template
  - https://www.dropbox.com/sh/84ulhmgklir8ba5/AAArFPbHLEsoVf-VhUGmG8vsa?dl=0&preview=RHC+FQHC+Plan+Template+01.2017.pdf
- NARHC/HRSA free webinar on emergency preparedness
  - https://www.hrsa.gov/rural-health/resources/conference-call/index.html
- State Operations Manual (SOM Appendix Z
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-29.pdf
- CMS FAQs and other links
  - https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

Rural Health Clinic Billing Compliance

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RHC Overview

What Is Different About RHC Billing?

RHC services are billed and reimbursed by Medicare (and Medicaid in some states) under an all-inclusive payment rate regardless of the type of practitioner (physician vs. midlevel) or the complexity of services performed (99212 vs. 99215, E/M vs. surgical procedure).

RHC services are billed to Medicare on the UB-04 claim form instead of the CMS 1500 form often used for billing physician services.

CPT/HCPCS codes are now reported for Medicare RHC billing purposes effective April 1, 2016 (more about this later).

RHC Overview

There are two types of RHCs;
cost reporting and billing for some services are slightly different for each:

- Independent RHCs submit an RHC cost report to one of five regional fiscal intermediaries (transitioning to MAC).
- Provider-based RHCs submit an RHC cost report as a subset of the host provider (usually a hospital).

Payment Calculations

- The upper payment limit for RHC for 1/1/17 through 12/31/17 is $82.30 per visit (based on the Medicare Economic Index, MEI, 1.2 percent increase over the 2016 rate of $81.32)
  - However, no upper payment limit for RHCs that are provider-based to a hospital with less than 50 beds

Payment Calculations

RHC Payment Examples

- Customary charge for 99213 is $120
- Assume Medicare fee schedule allowable is $70
- Medicare encounter rate is $160:
  - Limited to $80 for independent RHC
  - No limit for provider-based RHC - Available beds < 50
- Deductibles have been met already

Payment Calculations

Comparison Between RHCs and Part B Payment Example

Description	RHC Amount (Independent)	RHC Amount (Provider-Based)	Part B Amount
Customary Charge	$120.00	$120.00	$120.00
Patient Copay	24.00	24.00	14.00
Medicare Pays	64.00	128.00	56.00
Total Payment	88.00	152.00	70.00
Contractual Adjustment	32.00	(32.00)	50.00

Payment Calculations

Does it matter how we code the visit if we get paid the same rate?

- Patient payment is affected
  - Medicare considers overcoding a violation of the fraud and abuse regulations because of the additional reimbursement
  - Medicare considers undercoding a violation of the fraud and abuse regulations because it encourages patients to overuse the clinic

Conclusion: Yes, it Matters!

RHC HCPCS Reporting Requirements

- Compliance with national coding standards and requirements.
- Collect data on RHC services to better inform policies.
- Increase accuracy of RHC claims processing

RHC HCPCS Reporting Requirements

This presentation contains billing and payment examples. The UB-04 sample, HCPCS codes, revenue codes, and the associated charges used in the slides are for illustrative purposes only and should not be used as a guideline for billing or setting rates.

The examples use the following fictional charges for illustrative purposes only:

- 99213 = $140.00
- 90834 = $160.00
- G0101 = $80.00
- 12002 = $200.00
- G0117 = $100.00
- 36415 = $6.00
- 69200 = $150.00

New RHC HCPCS Reporting

Qualifying Visit Line (Revenue code 052x or 0900)

- Report charges for all services furnished during the encounter minus charges for preventive services.
- Attach "CG" modifier on the Qualifying Visit Line (including preventive services).
- Charges for the qualifying visit represent the amount that will be used to assess coinsurance and deductible.

Additional Service Line(s)

- Report each additional service furnished with the most appropriate revenue code with charges $0.01 or greater.

Some charges are displayed twice

- On the line with the qualifying visit and on the service line for the specific service.

Example 1 – Medicare UB-04

Patient comes to the RHC for a medical visit and venipuncture on

October 1, 2016

Example is for illustrative purposes only

UB-04 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$146.00
0300	Venipuncture	36415	10/01/2016	1	$ 6.00
001	*TOTAL CHARGE*				*$152.00*

Example 2 – Medicare UB-04

Patient comes to the RHC for a
medical visit and preventive health services on
October 1, 2016
Example is for illustrative purposes only

UB-04 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$146.00
0521	Breast/pelvic	G0101	10/01/2016	1	$ 80.00
0300	Venipuncture	36415	10/01/2016	1	$ 6.00
001	*TOTAL CHARGE*				*$232.00*

Example 3 – Medicare UB-04

Patient comes to the RHC for a
medical visit and simple wound repair

October 1, 2016

Example is for illustrative purposes only

UB-04 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$346.00
0521	Wound repair	12002	10/01/2016	1	$200.00
0300	Venipuncture	36415	10/01/2016	1	$ 6.00
001	*TOTAL CHARGE*				*$552.00*

Example 4 – Medicare UB-04

Patient comes to the RHC for a
medical visit and behavioral health visit

October 1, 2016

Example is for illustrative purposes only

UB-04 LINE ITEM ILLUSTRATION					
FL42 REV. CODE	FL43 DESC	FL44 HCPCS/ CPT	FL45 DOS	FL45 UNITS	FL47 TOTAL CHARGE
0521	OV Est 3	99213 CG	10/01/2016	1	$140.00
0900	BH session	90834 CG	10/01/2016	1	$160.00
001	*TOTAL CHARGE*				*$300.00*

Non-RHC Services - Lab

Billing Lab Services Performed *in* an RHC

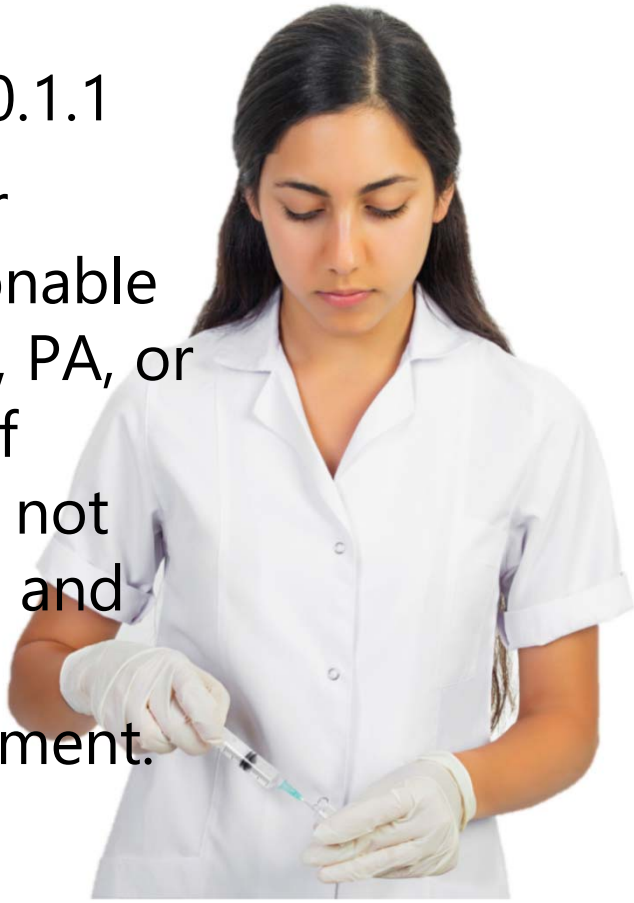
Although RHCs and FQHCs are required to furnish certain laboratory services (for RHCs see Section 1861(aa)(2)(G) of the Act and for FQHCs see Section 330(b)(1)(A)(i)(II) of the PHS Act), laboratory services are not within the scope of the RHC or FQHC benefit. When clinics and centers separately bill laboratory services, the cost of associated space, equipment, supplies, facility overhead, and personnel for these services must be adjusted out of the RHC or FQHC cost report. This does not include venipuncture, which is included in the all-inclusive rate when furnished in the RHC or FQHC by an RHC or FQHC practitioner and as part of an RHC or FQHC visit.

MLN Matters Number MM8504, November 22, 2013

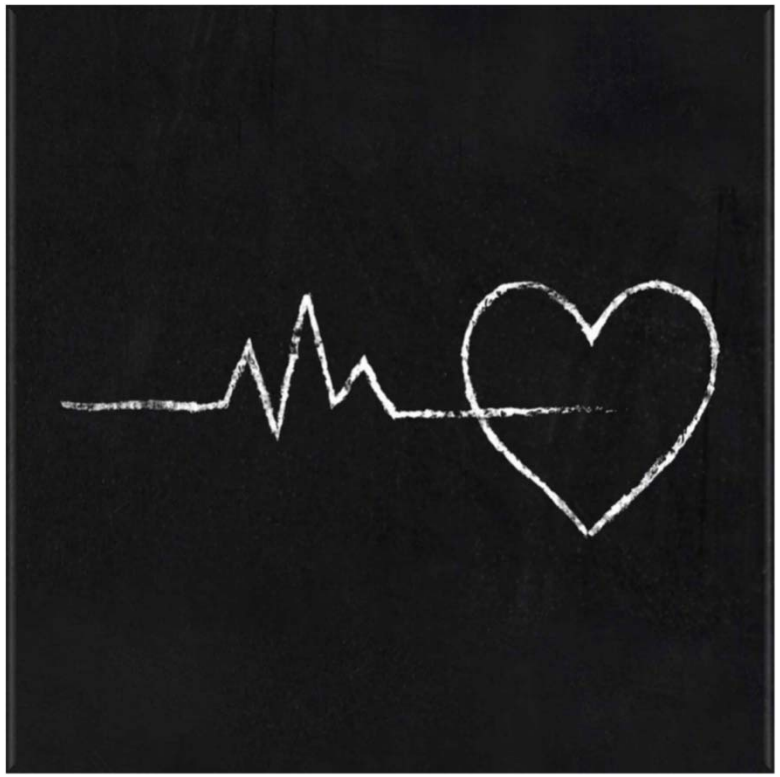
Preventive Services in the RHC

Pneumococcal and Influenza Vaccines

See CMS Publ. 100-02, Chapter 13, Section 210.1.1



Pneumococcal and influenza vaccines and their administration are paid at 100 percent of reasonable cost. When an RHC practitioner (physician, NP, PA, or CNM) sees a beneficiary for the sole purpose of administering these vaccinations, the RHC may not bill for a visit; however, the cost of the vaccines and administration are included on the annual cost report and separately reimbursed at cost settlement. These costs should not be reported on an RHC claim when billing for RHC services, and the beneficiary pays no Part B deductible or coinsurance for these services.



Provider-Based Status

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Provider-Based Requirements

- The elective status as a Rural Health Clinic provider type for Medicare and Medicaid purposes requires that a specific set of criteria be met as a condition of RHC participation.
- The provider-based element of PB-RHC status overlays numerous additional requirements as an integral component of an existing Medicare provider, generally a hospital.
- A PB-RHC must meet the requirements of provider-based status as well as maintain compliance with the Rural Health Clinic conditions of participation to obtain its favorable reimbursement for Medicare and Medicaid.

Provider-Based Requirements

Requirements and Obligations 42 CFR 413.65 (excerpts)

- Clinic operation under the ownership and control of the main provider:
  - 100% owned by the provider, same governing body, common bylaws and operating decisions of the governing body, final responsibility, and administrative decisions

Provider-Based Requirements

Requirements and Obligations (continued)

- Administration and supervision:
  - Direct supervision, accountability, integration (HR, billing, payroll)
- Clinical services:
  - Clinical privileges, chief medical officer, quality assurance and utilization review, medical records integration (unified retrieval systems)

Provider-Based Requirements

Requirements and Obligations (continued)

- Financial integration:
  - Shared income and expenses, cost center on the MC Cost Report
  - Costs included in the main provider's trial balance
- Public awareness:
  - Signage (use hospital's name, not parent name or system)
  - Common registration forms
  - Common billing statements
- Other requirements (e.g., management contracts, EMTALA, etc.)

Provider-Based Requirements

Example

413.65(e)(2)(iii)

> The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services.
>
> Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are . . . contracted.

Filing the Attestation Statement

- ✓ Filed with the Medicare Contractor (MAC).
- ✓ Not a required filing, so no standard CMS forms.
- ✓ Sample forms provided by MAC (website download).
- ✓ Final approval by CMS regional office.
- ✓ Subject to interpretation.

Filing the Attestation Statement

Attestation Example

Wisconsin Physicians Service (WPS)

http://www.wpsmedicare.com/j8macparta/departments/audit_reimbursement/_files/wps_attest_form.pdf

- Must not be submitted until after CMS 855 approval.
- Do not submit until after RHC Tie-In notice (RHC provider number is required).
- Include supporting documentation.
- 20-page Attestation document.

Filing the Attestation Statement

Attestation Example (continued)
Selected excerpts

"Provide pictures of provider-based signage clearly identifying the provider-based entity as part of the main provider (e.g., a photo of the sign, website, yellow pages, patient forms, etc.). Advertisements that only show the facility to be part of or affiliated with the main provider's healthcare system are not acceptable."

Filing the Attestation Statement

Attestation Example (continued)
Selected excerpts

"Submit list of all clinical staff (i.e., physicians, nurses, physical therapists, radiology technicians, etc.) working at the facility or organization showing job titles and name of employer. Also include whether professional staff have clinical privileges at the main provider."

Filing the Attestation Statement

Reporting Changes to the Attestation

42 CFR 413.65(c) ***Reporting of material changes in relationships***

A main provider that has had one or more facilities or organizations considered provider-based also may report to CMS any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that would affect the provider-based status of the facility or organization.

Questions?

Thank you!

Today's Presenters:

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