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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 Tenet Healthcare Corporation or 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. **“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 shall 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

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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. **“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

G. **“Disproportionate Share Hospital”** (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.

IV. POLICY:

Tenet Facilities shall 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 Medicare’s recognition of such facilities as provider-based.


V. PROCEDURE:

A. Tenet Facility Implementation

The Tenet Facility shall ensure that this policy is adhered to by following all of the steps set forth herein.

1. Step 1: Determine if the Provider-Based Rules Apply

If the PB Entity provides (a) inpatient or outpatient services Off-Campus or (b) outpatient services On-Campus and there will be a payment differential depending upon whether the entity is free-standing or

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provider-based, then the following steps need to be taken to determine if the PB Entity needs to meet the requirements of the Medicare provider-based status rules and seek provider-based determination.

2. Step 2: Determine if the Tenet Entity is Exempt from the Medicare Provider-Based Rules

The Medicare provider-based rules do not apply to the following types of services or facilities and thus, no further action is necessary:

- a. Ambulatory surgical centers
- b. Comprehensive outpatient rehabilitation facilities
- c. Home health agencies
- d. Skilled nursing facilities
- e. Hospices
- f. Inpatient rehabilitation units excluded from inpatient prospective payment system (PPS) for acute hospital services
- g. 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
- h. For periods prior to December 31, 2005, Facilities, other than those operating as part of a CAH, furnishing only physical, occupational or speech therapy to ambulatory patients¹
- 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

¹Under applicable regulations, this exclusion applied only for so long as the applicable annual cap on coverage of physical, occupational, or speech therapy remained suspended by the action of subsequent legislation. This legislative suspension expired on December 31, 2005. Accordingly, outpatient therapy facilities may now be eligible for provider-based status.

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3. Step 3: Determine Compliance with the Medicare Provider-Based Rules

a. On-Campus PB Entities must comply with the following requirements. If these requirements are met, a self attestation shall be submitted pursuant to Step 4 below. If these elements are not met, the Hospital's provider number shall not be used for billing purposes, the PB Entity must obtain a separate provider number, and the PB Entity's costs shall not be treated as reimbursable on the PB Entity's Medicare or Medicaid cost report.

(1) Licensure. The Hospital and the PB Entity must be operated under the same license, except in areas where the state requires a separate license for the department of the main provider, or in states where state law does not permit licensure of the Hospital and the PB Entity.


(2) Clinical Services. The clinical services of the PB Entity and the Hospital are integrated as evidenced by the following:

(a) The professional staff of the PB Entity has clinical privileges at the Hospital.


(b) The Hospital maintains the same monitoring and oversight of the PB Entity as it does for any other department of the Hospital.

(c) The medical director of the PB Entity maintains a reporting relationship with the chief medical officer or other similar official of the Hospital that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the Hospital and the chief medical officer or other similar official of the Hospital, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the Hospital.


(d) Medical staff committees or other professional committees at the Hospital are responsible for medical activities in the PB Entity, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based determination and the Hospital.

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- (e) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the Hospital.
 - (f) Inpatient and outpatient services of the PB Entity and the Hospital are integrated, and patients treated at the PB Entity who require further care have full access to all services of the Hospital and are referred where appropriate to the corresponding inpatient or outpatient department or service of the Hospital.
- (3) Financial Integration. The financial operation of the PB Entity is fully integrated within the financial system of the Hospital as evidenced by shared income and expenses between the Hospital and the PB Entity. The costs of a PB Entity that is a hospital department are reported in a cost center of the provider, costs of a provider-based facility or organization other than a hospital department are reported in the appropriate cost center or cost centers of the main provider, and the financial status of any provider-based facility or organization is incorporated and readily identified in the main provider's trial balance.
 - (4) Public Awareness. The PB Entity is held out to the public and other payers as part of the Hospital. When patients enter the PB Entity they are aware that they are entering the Hospital and are billed accordingly. For example, signs and promotional material referencing the PB Entity clearly indicate that it is a component of the Hospital.
 - (5) Management Agreements. If the entity is under a management services contract:
 - (a) The administrative functions of the PB Entity are integrated with those of the Hospital; and
 - (b) The Hospital has significant control over the operation of the PB Entity.
 - (6) Under Arrangements. The Hospital may not provide all patient services at the PB Entity on an "under arrangements" basis; thus, the Hospital must use its own personnel to furnish at least some portion of the care provided at the PB Entity.

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- (7) Other Requirements for PB Entities that are Departments of Hospitals.
- (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 and 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](#).
- (8) Joint Ventures. Generally, PB Entities that are organized as a joint venture (*i.e.*, it is owned by two or more providers engaged in a joint venture) are not permissible under the


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Medicare Provider-Based laws. A PB Entity may be structured as a joint venture if (and only if) the PB Entity:


- (a) Is partially owned by at least one Hospital;
- (b) Is located On Campus of the Hospital that partially owns it;
- (c) Is provider-based to the Hospital on whose campus the PB Entity is located; and
- (d) Meets all the requirements applicable to provider-based facilities and organizations that are On Campus (see Step 3.a. above).

If the PB Entity that is seeking provider-based determination is not a joint venture or is a joint venture and meets requirements in Step 3.a.(8)(a)-(d) above, then proceed to Step 4 below. If the Tenet Entity that is seeking provider-based determination is a joint venture and does not meet these requirements, the Hospital's provider number shall not be used by the joint venture for billing purposes, the joint venture must obtain a separate billing number, and the joint venture's expenses must not be treated as reimbursable expenses on the Hospital's Medicare or Medicaid cost report.

- b. PB Entities that are located Off-Campus must comply with all of the following requirements in addition to those listed in Step 3.a. above. If these requirements are met, a self attestation needs to be submitted pursuant to Step 4 below. If these elements are not met, the Hospital's provider number shall not be used for billing purposes and the PB Entity must obtain a separate provider number except if CMS believes that the PB Entity submitted a request for a provider-based determination, and CMS has indicated that the PB Entity may continue to be paid under the provider-based rules until a determination is made.
 - (1) Operation under the Ownership and Control of the Main Provider. The PB Entity is operated under the ownership and control of the Hospital. Operation under the ownership and control of the Hospital is evidenced by the following:


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- (a) The business enterprise that constitutes the PB Entity is 100 percent owned by the Hospital.
 - (b) The Hospital and the PB Entity seeking status as a department of the Hospital have the same governing body.
 - (c) The PB Entity is operated under the same organizational documents as the Hospital. For example, the PB Entity must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.
 - (d) The Hospital has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits or code of conduct), and final approval for medical staff appointments in the PB Entity.
- (2) Administration and Supervision. The reporting relationship between the PB Entity and the Hospital must have the same frequency, intensity, and level of accountability that exists in the relationship between the Hospital and one of its departments. Compliance with the following is necessary:
- (a) The PB Entity is under the direct supervision of the Hospital.
 - (b) The PB Entity is operated under the same monitoring and oversight by the Hospital as any other department of the Hospital, and is operated just as any other department of the Hospital with regard to supervision and accountability. The PB Entity director or individual responsible for daily operations at the entity (i) maintains a reporting relationship with a manager at the main Hospital that has the same frequency, intensity, and level of accountability that exists in the relationship between the Hospital and its existing department; and (ii) is accountable to the governing body of the Hospital, in the same manner as any department head of the provider.

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- (c) The following administrative functions of the PB Entity are integrated with those of the Hospital where the PB Entity 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 function for the PB Entity and Hospital, or the administrative functions for both the PB Entity and the Hospital are (i) contracted out under the same contract agreement; or (ii) handled under different contract agreements, with the contract of the PB Entity managed by the Hospital.
- (3) Location in Immediate Vicinity. The PB Entity is located within a 35-mile radius of the campus of the Hospital, unless one of the following is satisfied:²
- (a) The PB Entity is owned and operated by a Disproportionate Share Hospital (DSH) that, in turn, is owned and operated by (i) a state or local government or a nonprofit corporation formally granted powers by a state or local government, or (ii) a private hospital that has a contract with a state or local government including the operation of clinics located off the main campus of the hospital to assure access in a well-defined service area to health care services for low-income individuals who are not entitled to benefits under Medicare or Medicaid.
- (b) The PB entity demonstrates a high level of integration with the hospital by showing it meets all of the other provider-based criteria and demonstrates it services the same patient population as the hospital by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with CMS, and for each subsequent 12-month period,

²A PB Entity may qualify for provider-based status under this section only if the PB Entity and the Hospital are located in the same state or, when consistent with the laws of both states, in adjacent states.

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- (i) At least 75 percent of the patients served by the PB Entity reside in the same zip code areas as at least 75 percent of the patients served by the Hospital; or
 - (ii) At least 75 percent of the patients served by the PB Entity who required the type of care furnished by the Hospital received that care from the Hospital.³
 - (iii) The PB Entity is an RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in [42 CFR § 412.2\(f\)\(1\)\(iii\)](#), and has fewer than 50 beds, as determined under [42 CFR § 412.105\(b\)](#).
- (4) Management Agreements. If the entity is under a management services contract:
- (a) The non-physician clinical staff of the PB Entity, other than the management staff and staff who furnish patient care services of a type that would be paid for by Medicare under a fee schedule established by regulations at [part 414 of chapter IV of Title 42](#), must be employed by the Hospital (and may not be leased from the management company).
 - (b) The administrative functions of the provider-based entity are integrated with those of the main provider.
 - (c) The Hospital has significant control over the operation of the PB Entity.
 - (d) The management contract must be held by the main provider (and not a parent or other organization).
- (5) 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-

³If the PB Entity is unable to meet the criteria in Subsection V.A..3.b.(2)(b)(i) or (ii) because it was not in operation during all of the 12-month period described in this section, the PB Entity is located in a zip code area included among those that, during all of the 12-month period described in this section, accounted for at least 75 percent of the patients served by the Hospital.

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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.⁴ See Exhibit A for a sample coinsurance notification form.


4. Step 4: Submission of Self Attestation
 - a. Initial Submission

All Tenet entities meeting the provider-based requirements for On Campus and/or Off-Campus facilities must submit a self attestation form to their Medicare Administrative Contractor (MAC) using the MAC’s attestation form (found on the MAC’s website). The attestation form calls for back up to the representations made by the Hospital. Completion and inclusion of the application form provides the appropriate analysis for the hospital and CMS with regard to compliance with the provider-based standards. Attached as Exhibits B (On-Campus) and C (Off-Campus) are lists of documentation required to be submitted with the attestation.

- (1) Government Programs and Regional Counsel must review and approve the self-attestation, application and supporting documentation prior to submission. All material should be submitted at least 30 days prior to the planned submission date.

If the PB Entity has not previously submitted a self-attestation form, and/or provider-based status represents a change in the entity’s business, the Hospital must notify its Hospital Compliance Officer. The Hospital Compliance Officer will investigate the matter according to the procedures described in [Regulatory Compliance Policy COMP-RCC 4.21 Internal Reporting of Potential Compliance Issues](#).

⁴ 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.

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Once complete, the attestation with accompanying application and documents is to be submitted to the MAC with a complete copy to the CMS Regional Office which has jurisdiction over the state in which the main provider is located.

b. Subsequent Submissions

A subsequent attestation must be submitted to the CMS Regional Office if there is a material change in the relationship between the Hospital and the PB Entity, such as a change in owner of the PB Entity or organization or entry into a new or different management contract that would affect the provider-based status of the Hospital. All subsequent submissions must be approved in advance by Government Programs and Regional Counsel.

5. Step 5: Professional Services Coverage Agreement

The Hospital shall consult with Regional Counsel regarding whether entering into a Professional Services Coverage Agreement is necessary. A form of the Professional Services Coverage Agreement can be found in Tenet Law Department's [Contractual Arrangements Manual \(CAM\)](#).

6. Step 6: Archive Documents


The Hospital shall scan and upload a complete copy of the attestation and materials submitted to the MAC and CMS into the eCATS system as required by [Law Department Policy L-15 Electronic Contract Approval Term Sheet Policy](#) (see Section IV.D. Provider Licenses/Accreditations). The Hospital also shall scan and upload all relevant data for the attestation.

B. Auditing and Monitoring

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

C. 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 Hospital Compliance Officer.

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D. 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."](#)

VII. ATTACHMENTS:

- Attachment A – Off-Campus Medicare Outpatient Coinsurance Notice
- Attachment B – On-Campus Provider-Based Status Documentation Requirements
- Attachment C – Off-Campus Provider-Based Status Documentation Requirements

[Hospital Letterhead]

Off-Campus Medicare Outpatient Coinsurance Notice

To our Medicare patients:

Medicare regulations require us to provide you with a notice of your potential financial liability for the hospital services you will receive.

We are required to advise you that because the services are furnished by a department of (Hospital Name), you will incur a coinsurance liability to the hospital that may be different than the coinsurance liability you would incur if the services were furnished in an entity that is not hospital-based. At this time we can provide you with the following information on the estimated amount of your coinsurance liability:

___ Your coinsurance liability for hospital services is *estimated* to be \$ _____, based on our current information about scheduled services.

___ We cannot provide you with an estimate of your liability at this time because we do not know the exact type and extent of services that you may need.

The actual amount of your coinsurance liability to the hospital may be different from any estimate that is provided above. Actual coinsurance liability will be based on the services that you receive, and is also subject to final determination by the Medicare program.

If you are enrolled in a state medical assistance program (Medi-Cal or Medicaid) your coinsurance liability may be reduced or eliminated by law. **Your coinsurance liability for hospital services is separate from the Medicare coinsurance liability that you may owe for any physician or professional services provided to you in conjunction with hospital services.**

I have read the foregoing and understand that I will incur a liability to the hospital for Medicare coinsurance as permitted by law.

Signature of patient or authorized representative

Date

Provider-Based Status Documentation Requirements
On-Campus

1. Detailed map to verify the distance from the main provider
2. Copy of Hospital's license
3. Copy of Joint Commission accreditation
4. Information about personnel/professional staff:
 - a. List of all personnel working at the facility showing their job titles/employer
 - b. Information as to whether professional staff of the facility have clinical privileges at the main provider
 - c. Description of the level of monitoring and oversight of the facility by the main provider (as compared to other departments)
 - d. Description of the responsibilities and relationships between the medical director of the facility, the chief medical officer and the medical staff committees.
5. Copy or description of the policy utilized in record retrieval
6. Information about how inpatient and outpatient services of the facility and the main provider are integrated and examples of integration of services, including data on the frequency of referrals from inpatient to outpatient or vice versa.
7. Copy of appropriate section of the main provider's chart of accounts or trial balance to show the location of revenues and expenses.
8. Examples that entity is clearly identified as part of the main provider (i.e., patient registration forms, letterhead, advertisements, signage).
9. EMTALA and other relevant documentation to verify compliance under Question 5 of the CMS model attestation form.

Provider-Based Status Documentation Requirements
Off-Campus

1. Detailed map to verify the distance from the main provider
2. Copy of Hospital's license
3. Copy of JCAHO accreditation
4. Information about personnel/professional staff:
 - a. List of all personnel working at the facility showing their job titles/employer
 - b. Information as to whether professional staff of the facility have clinical privileges at the main provider
 - c. Description of the level of monitoring and oversight of the facility by the main provider (as compared to other departments)
 - d. Description of the responsibilities and relationships between the medical director of the facility, the chief medical officer and the medical staff committees.
5. Copy or description of the policy utilized in record retrieval
6. Information about how inpatient and outpatient services of the facility and the main provider are integrated and examples of integration of services, including data on the frequency of referrals from inpatient to outpatient or vice versa.
7. Copy of appropriate section of the main provider's chart of accounts or trial balance to show the location of revenues and expenses.
8. Examples that entity is clearly identified as part of the main provider (i.e., patient registration forms, letterhead, advertisements, signage).
9. EMTALA and other relevant documentation to verify compliance under Question 5 of the CMS model attestation form.
10. Articles of Incorporation and Bylaws for both the Hospital and the PB Entity if there is a joint venture.
11. Describe who has final approval for administrative decisions, contracts with outside parties, personnel policies and medical staff appointments for the facility.
12. List of administrative staff (position/titles only) at the main provider and the entity requesting provider-based status that have a reporting relationship.
13. Provide a copy of the organization's organizational chart, including the main provider and the entity requesting provider-based status and show which department of the main provider the entity is included.
14. Provide a written description of the entity director's reporting requirements and accountability procedures for day-to-day operations.
15. Submit a list of administrative functions at the facility that are integrated with the main provider.
16. Coinsurance liability notice for Medicare beneficiaries.