

**WPS Medicare A&R
Provider-Based Designation Attestation Statement**

Do **not** submit with Provider Enrollment Documentation:

Email to Provider.Based@wpsic.com or **Mail** to the "**Medicare Audit Part A, Attn. Noel Blase, Provider Based Attestation Coordinator.**" See #4 for mailing address.

Main Provider Medicare No. (CMS Certification # - CCN): _____

Main Provider Name: _____

Name of Provider-Based unit: _____

The following is an example created by WPS for an attestation of provider-based compliance. If you elect to use this form or any other format, CMS recommends that you place the initial page of the attestation on the official letterhead of the main provider

THE FOLLOWING STEPS ARE IMPERATIVE TO AVOID A REJECTED PROVIDER-BASED ATTESTATION:

- 1.) The Provider-Based Attestation must not be submitted until after the CMS Form 855 has been approved by the Provider Enrollment Area to add the additional location to the hospital. Once the 855 has been submitted to the Provider Enrollment Area and you have received an approval from them, then you can submit the Provider-Based Attestation to the Audit area. Do not send the two forms together.
- 2.) For a provider-based RHC, do not submit the Provider-Based attestation until after the tie in has been received from CMS with the number for the RHC. WPS will not be able to process any Provider-Based attestation when the RHC provider number is not included.
- 3.) Ensure that all supporting documentation has been included with the attestation. For example, if the license (or support for why there wouldn't be a separate license) is missing, a request will be made for such information. If the request is not fulfilled within 30 days, the MAC must make a recommendation for denial to the CMS RO.
- 4.) To be considered a valid submission, the Provider-Based Attestation must be submitted to the below address:

Preferably send electronically to: Provider.Based@wpsic.com
Or

Part A Medicare Audit:

WPS

Medicare Audit Part A

Attn: Noel Blase, Provider Based Attestation Coordinator

PO Box 8696

Madison, WI 53708-8696

Overnight Mail:

WPS

Medicare Audit Part A

Attn: Noel Blase, Provider Based Attestation Coordinator

1717 W. Broadway

Madison, WI 53708-8696

Please note that, per 42 CFR 413.65, provider-based determinations in relation to hospitals ARE NOT made for the following facilities:

- Ambulatory Surgical Centers (ASCs) as a Supplier only
 - Does not include a provider that wants to bill under the Hospital's Medicare provider number.
- An ASC that wants to bill under the Hospital's Medicare provider number can submit a provider-based attestation if they wish to have a determination as provider-based. If a Part B ASC provider number/CCN has been issued, it must be terminated before the facility can be considered provider-based.
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Home Health Agencies (HHAs)
- Skilled Nursing Facilities (SNFs)
- Hospices
- Inpatient Rehabilitation Hospital (IRF) Units that are excluded from the inpatient prospective payment system (PPS) for acute hospital services
- Independent Diagnostic Testing Facilities (IDTFs) furnishing only services paid under a fee schedule (subject to CFR 413.65(a)(1)(ii)(G).
- Facilities, other than those operating as parts of CAHs, furnishing only physical, occupational, or speech therapy to ambulatory patients, throughout any period during the annual financial cap amount on payment for physical, occupational, or speech therapy
- End Stage Renal Dialysis (ESRD) Facilities
- Departments of providers that perform functions necessary to 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, medical records departments, etc.)
 - Considered also as overhead or non-revenue producing departments
- Ambulances
- Rural Health Clinics (RHCs) affiliated with Hospitals having 50 or more beds
- Facilities that only furnish clinical diagnostic laboratory (CDL) services paid under fee schedule
- Other types of services that only furnish services paid under a fee schedule

Provider-based determinations are also not made unless there is a reimbursement (payment) impact between how the facility would bill as provider-based versus how they would bill if they were considered freestanding. An exception is made for remote locations of a hospital that are providing the same services as the main hospital. In these cases, a provider-based determination can still be requested.

Tips to consider if the provider needs to attest or not:

Provider-based attestation IS NOT necessary if:

- a. The payment is the **same** whether it is free-standing or provider-based, or
- b. The beneficiary's liability for the coinsurance or deductible amount would not be affected, or
- c. The facility/organization or entity that only provides inpatient services (services that are integral to the operation of the main provider) and do not furnish services of a type for which separate payment could be claimed under Medicare or Medicaid, or
- d. The provider plans to continue to bill Part B. Provider-based attestation ONLY affects how they would be paid through Medicare Part A through the MAC.

Examples of categories that may be allowed to submit a provider-based attestation: ASC where the provider wants to bill under the Hospital provider number and the Part B ASC CCN has been terminated, CAH facilities that provides PT, OT, ST to ambulatory patients where they desire to bill under the hospital provider number and multi-campus hospitals that desire to bill under one provider number.

As you complete this form, pay attention to the requirements and obligations relative to the type of provider-based facility/organization (i.e. Dept. of a Provider, Remote Location of a Hospital, Satellite Facility, Provider-Based Entity) and the location (i.e. on or off campus) of the provider-based facility/organization in relationship to the main provider.

References: PM-A-03-030, CFR 413.65, 413.174 (for hospital based ESRDs), 483.5 (for SNFs & NFs)

GENERAL INFORMATION

1) Main Provider (e.g., Hospital) Information:

Name: _____

Provider # / CCN: _____

NPI: _____

Exact Physical Address:

2) Provider-Based Facility Information:

Name: _____

Provider # / CCN: (if app.) _____

NPI: _____

Exact Physical Address: (Note: If more than one provider based entity is operating at the additional location, the suite or room number of each entity must be added to PECOS.)

2a) Please submit a copy of the provider-based provider enrollment recommendation or approval letter or CMS letter and tie-in notice granting approval to operate as a Medicare Provider.

Note: If the provider-based entity does not have the recommendation of approval from the MAC Provider Enrollment or CMS approval letter or tie-in notice from CMS, the provider attestation will be returned. The provider will need to resubmit the documentation once received.

3) Attestation Contact Name and Phone Number:

Name: _____

Phone Number: _____

Email Address: _____

Physical Address (if different from Main Provider):

Is this contact directly employed by the Medicare provider? ☐ Y/N**If no, please complete the following authorization. Note that we will not be able to contact any non-provider contact without this signed authorization.****I hereby authorize WPS and its employees to contact the above listed individuals(s) and share any information, requests, etc. related to the above provider-based attestation review. This authorization will be in effect only for the specific review detailed above. This authorization may be terminated earlier by notifying WPS of a rescission of this authorization or a new contact that should be used.****Signature and Title of Authorized Administrator of Medicare Provider****Date**

4) Main Provider's MAC: _____

4a) Main Provider Type:
 Acute Care _____ CAH _____ SCH _____ Other: _____

5) Is the main provider accredited? _____ (Y or N)

5a) If yes, by whom? _____

6) Date the main provider began billing services rendered at the facility/organization under the main provider's Part A provider number. _____

Indicate Y or N:

7) _____ Is the facility/organization part of a multi-campus hospital?

8) _____ Is the facility a Federally Qualified Health Center (FQHC)?

Note: If you responded yes to #8 above, and if the FQHC meets the criteria at Section 413.65(n), it need not attest to its provider based status. The provider-based rules do not apply to other FQHCs that do not meet the criteria at section 413.65(n), and an attestation should not be submitted.

9) _____ Is the facility an RHC Note: Has the RHC CCN been issued?

9a) _____ If the facility is an RHC, does the main provider have 50 or more beds? **OR**

9b) _____ If the facility is an RHC, is the RHC otherwise eligible for the RHC upper limit payment exception?

Exh. _____ **Submit a copy of the most recent filed cost report worksheet S-3.**

9c) If you responded yes to either 9a or 9b, please do not submit this attestation as CMS will not make a provider-based determination if the RHC is part of a main provider that has 50 or more beds or is otherwise eligible for the RHC upper payment exception.

9d) _____ If the provider-based entity is a Ambulatory Surgical Center (ASC), has the Part B provider number or CCN been terminated.

Exh. _____ **Submit a copy of the Part B - ASC provider number or ASC CCN termination letter.**

9e) _____ Are patient care services at the facility furnished under arrangements?

Exh. _____ If Yes, provide the arrangement contracts.

Due to the voluntary nature of the provider based attestation process, the facility/organization requesting provider-based status may have self-determined their adherence to the regulations and started providing these services and billing under the main provider number before they decided to submit an attestation for an official determination. On the other hand, some facilities may begin by billing as free standing and then decide to file an attestation before they start billing as provider-based.

Enter appropriate dates below:

10) _____ Date the Provider began providing services and billing as provider-based-- **OR** - -

_____ Date the Provider plans to begin providing services and billing as provider based

Note: If either of these dates are after the effective date of the facility's date in PECOS, please attest the facility will not bill as provider based status prior to the date listed in this step.

11)	Type of Filing: (Place an X by the selection that applies) a) _____ Initial attestation (1st time attesting), --OR - - _____ Re-attesting - please indicate if this attestation is adding, deleting or changing previous b) _____ information b1) _____ If Re-attesting, are you: Adding, Deleting or Changing previous information? _____ If you stated you are: Adding, Deleting or Changing, please make certain to include the b2) _____ effective date. _____ Effective Date (if app.) : _____
12)	Please "X" the one that best describes the entity requesting provider-based status: _____ Department of the provider (such as wound care, cardiac rehab, medical clinic, therapy clinic, sports clinic, or other outpatient only services) _____ Satellite facility (co-located facilities, also called "Hospital within Hospital") _____ Remote location of a hospital (multi-campus facilities) _____ Provider-based entity (Rural Health Clinics (RHC)) _____ Other - explain:
13)	List the specific medical services (i.e. surgical, radiology, evaluation and management, etc.) the facility/organization requesting provider-based will provide:
14)	Note: Does not apply to remote locations. Note: that provider-based status is only granted when there is a difference in either Medicare reimbursement or patient's coinsurance liability between how the facility would be paid if it was treated as freestanding versus how it would be paid as Hospital-based. As an example, certain facilities may normally bill through the carrier for services as freestanding, whereas they will bill through the MAC for services as hospital-based. If there is no difference, do not submit this attestation. In the space below, describe the difference in payment that will result from billing as provider-based. Please do not use form types (UB-04 or CMS 1500) to describe payment differences.
SECTION A. ON-CAMPUS / OFF-CAMPUS DETERMINATION	
Indicate whether the facility/organization is "On-Campus" or "Off-Campus", per 413.65(a)(2), with the main provider. Select "X" only one: 1) _____ ON-CAMPUS - of the main provider (located within 250 yards from the main provider buildings) 2) _____ OFF-CAMPUS - of the main provider (located 250 yards or greater from the main provider buildings, but subject to 413.65(e)(3))	

I certify that I have carefully read the attached sections of the Federal provider-based regulations, before signing this attestation, and that the facility/organization complies with the following requirements to be provider-based to the main provider:

Initial ONE selection only:

1) _____ The facility/organization is "ON-CAMPUS" per 42 CFR 413.65(a)(2) and is in compliance with all applicable provider-based requirements/obligations (shown in the following attached pages) in 413.65(d) and 413.65(g), other than those in 413.65(g)(7). If the facility/organization is operated as a joint venture, I certify that the requirements under 413.65(f) have also been met. I am aware of, and will comply with, the requirement to maintain documentation of the basis for these attestations (for each regulatory requirement) and to make that documentation available to the Centers for Medicare & Medicaid Services (CMS) and to CMS contractors upon request.

OR

2) _____ The facility/organization is "OFF-CAMPUS" per 42 CFR 413.65(a)(2) and is in compliance with all applicable provider-based requirements/obligations (shown in the following attached pages) in 413.65(d) and 413.65(g). If the facility/organization is operated under a management contract / agreement, I certify that the requirements of 413.65(h) have also been met. Furthermore, I am submitting along with this attestation to the CMS, the documentation showing the basis for these attestations (for each regulatory requirement).

Please complete Section B for On-Campus OR Sections B & C for Off-Campus facilities and organizations (please indicate Yes or No for each requirement, unless otherwise stated):

Location:

On-Campus

(Enter "Y" or "N" by the below statement)

3) _____ The facility or organization is located within 250 yards of the main hospital.

Exh. _____ Submit a copy of the main hospital campus map, mapquest, etc. indicating the 250 yards and describing how the 250 yards was determined.

On Campus and Off- Campus

4) _____ Is the on/off-campus department utterly distinct from other healthcare space? This includes other physicians that are not associated with the main hospital that practice at the provider-based entity. The floor plans should indicate the suite or location of the provider-based entity and if there is any sharing (including waiting rooms, registration desk and hallways within the provider-based designated area) of independent physicians not associated with the main hospital located in the suite or location of the provider based entity.

Note: Floorplan should be well labeled indicating all rooms usage and area occupied by the provider-based entity.

Exh. _____ Please provide a description/floor plan/photos of the provider-based entities physical setting of the on/off campus department to gain understanding of how the space is separated from other healthcare spaces. Please consider any non-hospital staff and physicians that provide services within the clinic.

(Enter "Y" or "N" by the below statement)

5) _____ The facility or organization is located within a 35-mile radius of the campus of the potential main provider, except when the requirements in paragraphs 5b, 5c, 5d, or 5e of this section are met (please check below in the appropriate location if you qualify for any of the exemptions):

Exh. _____ **Please provide documentation that demonstrates the facility is located within a 35-mile radius of the main provider, maps or an online service such as MapQuest may be used. (Note, however, that under this policy, the 35-mile radius is measured by actual straight-line distance between the provider and the facility, not road miles).**

5.1) _____ Are Critical Access Hospital (CAH) and any provider-based locations located more than 35-mile drive (or 15 miles for mountainous terrain or only secondary roads) from another hospital or another hospital provider-based location? 42 CFR 485.610 (e) (2)

Exh. _____ **Please provide documentation supporting that no other (not owned by the CAH) hospital or other provider-based outpatient department are within 35-miles of the CAH.**

Location Requirement-Multi-State

Place an X in this box if NA

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5a) _____ If the facility or organization is attempting to qualify for provider-based status under this section, then the facility or organization and the main provider are located in the same State or, when consistent with the laws of both States, in adjacent States.

Exh. _____ **Include documentation from both states regarding any foreign business entity requirements (State reciprocal agreement), any additional licensure requirements, etc.**

Location Exemption 1

Place an X in this box if NA

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5b) _____ The facility or organization is owned and operated by a hospital or CAH that has a disproportionate share adjustment (as determined under 412.106 of Chapter IV of Title 42) greater than 11.75% or is described in 412.106(c)(2) of Chapter IV of Title 42 implementing section 1886(e)(5)(F)(i)(ii) of the Act and is:

5b.1) _____ Owned or operated by a unit of State or local government;

- 5b.2) _____ A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; OR – -
- 5b.3) _____ A private hospital that has a contract with a State or local government that includes 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 medical assistance under a Medicaid State plan).
- Exh. _____ **Submit a copy of a recent cost report to support DSH is greater than 11.75% and is owned or operated by a unit of State or local government; is a public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or a private hospital contracted with a State or local government.**

Location Exemption 2

Place an X in this box if NA

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- 5c) _____ The facility/organization demonstrates a high level of integration with the main provider, showing that it meets all of the other provider-based criteria and demonstrating it serves the same patient population as the main provider. This is done by submitting records showing that, during the 12-month period immediately preceding the 1st day of the month in which the attestation for provider-based status is filed with CMS, and for each subsequent 12-month period:
- 5c.1) _____ At least 75% of the patients serviced by the facility or organization reside in the same zip code areas as at least 75% of the patients served by the main provider; **OR - -**
- 5c.2) _____ At least 75% of the patients serviced by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at 75% of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); OR –
- 5c.3) _____ If the facility or organization is unable to meet the criteria in 1) or 2) directly above because it was not in operation during all of the 12-month period described paragraph 5b), the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in paragraph 5b, accounted for at least 75% of the patients served by the main provider.
- Exh. _____ **Submit records showing that the above criteria has been met 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.**

Location Exemption 3

Place an X in this box if NA

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- 5d) _____ **The facility or organization meets all of the following criteria:**
- 5d.1) _____ The facility or organization seeking provider-based status with respect to the hospital meets the criteria in 42 CFR 412.23(d) for reimbursement under Medicare as a children's hospital.
- 5d.2) _____ The facility or organization meets the criteria for identifying intensive care type units set forth in the Medicare reasonable cost reimbursement regulations under 42 CFR 413.53(d).

- 5d.3) _____ The facility or organization accepts only patients who are newborn infants who require intensive care on an inpatient basis.
- 5d.4) _____ The hospital in which the facility or organization is physically located is in a rural area as defined in 42 CFR 412.64(b)(1)(ii)(C).
- 5d.5) _____ The facility or organization is located within a 100-mile radius of the children's hospital that is the potential main provider.
- 5d.6) _____ The facility or organization is located at least 35 miles from the nearest other neonatal intensive care unit.
- 5d.7) _____ The facility or organization meets all other requirements for provider-based status under 42 CFR 413.65.

Submit documentation to support the hospital meets the criteria to be reimbursed under Medicare as a children's hospital; meets the criteria for identifying intensive care type units set forth in the Medicare reasonable cost reimbursement; Accepts only patients who are a newborn infants who require intensive care on an inpatient basis; physically located in a rural area; located within a 100-mile radius if the children's hospital that is the potential main provider; located at least 35-miles from the nearest other neonatal intensive care unit; and meets all other 42 CFR 413.65 requirements.

Exh. _____

Location Exemption 4 Place an X in this box if NA

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5e) _____ **Both of the following criteria are met:**

5e.1) _____ The facility or organization is an RHC that is otherwise qualified as a provider-based entity of a hospital that has fewer than 50 beds, as determined under 42 CFR 412.105(b); and,

5e.2) _____ The hospital with which the facility or organization has a provider-based relationship is located in a rural area, as defined in 42 CFR 412.64(b)(1)(ii)(C).

Submit support that the RHC's main hospital has fewer than 50 beds and is located in a rural area.

Exh. _____

SECTION B. The criteria at 413.65(d) that are applicable to ALL facilities; including those on-campus, are:

Licensure:

Enter Y or N by the question below:

1) _____ The department of the provider, remote location of a hospital, or satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, the remote location of a hospital, or the satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, the remote location of a hospital, or the satellite facility under a single license.

Select one of the below options with an X.

The provider-based entity is operating under the same license as the main provider, as allowed by this state. This single license has been included as documentation. Note: If your state issues a separate license or list the provider-based clinic on the hospital license for the provider-based entity the license must match PECOs and the name on the Provider-Based Attestation.

1a) _____

This state requires that the main provider and the provider-based entity have separate licenses. **Both licenses have been included as documentation.**

1b) _____

This state does not allow for any sort of licensure for the provider-based entity, whether with the main provider, or by itself. **Documentation from the state has been included to support this.**

1c) _____

Note: If the provider and facility/organization are located in a state having a health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers, the commission or agency has not found that the facility/organization is not part of the provider.

Provide a copy of the hospital license and a copy of the hospital license that lists the provider-based entity's addresses, or a letter from the State notifying the provider that the entity is included in the hospital's license. Note: If the State does not issue a separate license for the provider-based entity, please provide documentation that the State does not require the entity to be licensed separately (i.e., letter or e-mail from the state indicating a separate license is not issued for provider-based entities, or a copy of the State regulation).

Exh. _____

Note: If the current license is set to expire within 30-60 days submit both the current one and the next year's license

Failure to have this information available within 30 days of the MAC's request will lead to a recommendation for denial of this attestation and may require you to rebill any claims that were billed as provider-based. Please do NOT submit this attestation until the information is available.

Additional Licensure Comments:

Clinical Services Integration:

Enter Y or N by the statements below:

The clinical services of the facility or organization seeking provider-based status and the main provider are integrated. Note: Include both employed physicians and other clinical staff that provides services at this provider-based entity.

2) _____

2a) _____ Professional staff of the facility or organization have clinical privileges at the main provider.

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

Exh. _____

2b) _____ The main provider maintains the same monitoring and oversights of the facility as it does for any other department of the hospital.

Exh. _____ **Submit a written description of the level of monitoring and oversight of the facility by the main provider.**

2c) _____ The medical director of the facility seeking provider-based status maintains responsibilities and a reporting relationship with the chief medical officer or similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the chief medical officer or similar office of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

Exh. _____ **Describe how the provider-based medical director maintains a reporting relationship with the main provider chief medical officer.**

2d) _____ Medical staff and other professional committees at the main provider are responsible for medical activities in the facility, including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

Exh. _____ **Submit a description of the responsibilities and relationship between the Medical Director of the facility, the Chief Medical Officer of the main provider, and the Medical Staff Committees at the main provider.**

2e) _____ Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

Exh. _____ **Submit a written explanation of 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 facilities of the provider, or vice versa.**

2f) _____ Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

Exh. _____ **Submit a copy of the written policy in place that is utilized in record retrieval from both the main provider and the provider-based facility.**

Financial Integration:

Enter Y or N by the statement below:

The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of a facility or organization 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. (Note: the main provider or hospital must have their name on the top of the trial balance and include the time period the trial balance is for).

3) _____

_____ What is the financial statements run date?

_____ Include the trial balance revenue/expense grouping tying to most recent filed cost report W/S A and C for the provider based entity cost center.

Provide a copy of the most recent cost report filed W/S A and W/S C. If the provider-based entity is not listed on the cost report line 90 due to the date of the start-up of the provider-based entity, please provide an explanation.

Exh. _____

Provide a copy of the appropriate section of the main provider's chart of accounts and working trial balance that shows the location and date the trial balance was ran of the provider-based facility's revenues and expenses in relation to other departments within the hospital. Please highlight or indicate the applicable revenues and expenses.

Exh. _____

Financial Integration Comments:

Public Awareness:

Enter Y or N by the statement below:

4) _____ The facility or organization seeking status as a department of a provider, a remote location of a hospital, or a satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

Provide pictures of provider-based signage (both inside (Waiting room and registration desk) and outside signage) clearly identifying the provider-based entity a 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.

Exh. _____

Public Awareness Comments:

Obligations of a Hospital Outpatient Department & Hospital-Based Entity only; the facility or organization fulfills the obligation of:

CFR 413.65(g)(1) through (6) and (g)(8)

If the facility under review is neither a hospital outpatient department nor a hospital-based entity (i.e. RHC), then place an X in this box and skip to the requirements under number 6) Joint Ventures.

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5a.1) _____ The Hospital Outpatient Department is located **on the main campus** of the hospital.

Note: Hospital outpatient departments located on the main campus of the hospital comply with the anti-dumping rules in 42 CFR 489.20(l), (m), (q), and (r) and 42 CFR 489.24.

5a.2) _____ The Hospital Outpatient Department is located **off of the main campus** of the hospital, but it is a dedicated emergency department, as defined in 42 CFR 489.24(b).

Note: Hospital outpatient departments located off the main hospital campus and that are dedicated emergency departments, as defined in 42 CFR 489.24(b), comply with the anti-dumping rules in 42 CFR 489.20(l), (m), (q), and (r) and 42 CFR 489.24.

5a.3) _____ In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the anti-dumping rules at 489.24 of Chapter IV of Title 42, the notice is given as soon as possible after the existence of an emergency condition has been ruled out or the emergency condition has been stabilized.

Exh. _____ **If either of the above criteria are met, submit a copy of the main provider's EMTALA (anti-dumping) policies.**

5a.4) _____ The Hospital Outpatient Department is located **off of the main campus** of the hospital and is NOT a dedicated emergency department as discussed above.

Note: Hospital outpatient departments located off the main campus of the hospital that do not meet the definition of a dedicated emergency department are not required to comply with the anti-dumping rules but instead comply with 42 CFR 482.12(f)(3) Standard: Emergency Services.

Exh. _____ **Submit a staff policy/provision showing the process for when an emergency occurs on the provider-based premises.**

Note: The below requirements (5b-5f) apply to any hospital-based outpatient department (off campus OR on-campus). Place an X in this box and skip to step 5h if this does not apply to your facility:

5b) _____ Physician services furnished in hospital outpatient departments or provider-based entities (other than RHCs) are billed with the correct site-of-service so that appropriate physician and practitioner payment amounts can be determined under the rules of Part 414 of Chapter IV of Title 42.

Exh. _____ **Submit staff policy/provision to bill the site-of-service, physician contract discussing physician billing of site of service if contracted and hospital based or contracted physician CMS 1500 demonstrating the Place of Service (POS) 19 off-campus or 22 on-campus. It must be unredacted, applicable to a Medicare patient, the billing physician must be listed on the Key Listing of Personnel, and the address billed must match the address of the provider based location. (Medicare Learning Network (MLN) #MM9231) <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7631.pdf>**

5c) _____ Hospital outpatient departments comply with all the terms of the hospital's provider agreement.

Exh.	_____	Submit documentation demonstrating how the outpatient departments comply with all terms of the hospital's provider agreement e.g. Medicare Agreement and Conditions of Participation.
5d)	_____	Physicians who work in hospital outpatient departments or hospital-based entities comply with the non-discrimination provisions in 489.10(b) of Chapter IV of Title 42.
Exh.	_____	Submit the main hospital physician non-discrimination provision.
5e)	_____	Hospital outpatient departments (other than RHCs) treat all Medicare patients for billing purposes, as hospital outpatients. The departments do not treat some Medicare patients as hospital outpatients and others as physician office patients.
Exh.	_____	Submit the staff policy/provision that all Medicare patients are billed as hospital outpatients and not as physician's office patients. Examples: Medicare Billing Policies and Physician Contracts.
5f)	_____	72 hour or 3-Day Payment Window - In 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 for PPS hospitals and to hospitals and units excluded from PPS set forth at 412.2(c),(5) of Chapter IV of Title 42 and at 413.40(c),(2) of Chapter IV of Title 42, respectively. (Note: if the potential main provider is a Critical Access Hospital (CAH), enter "N/A" for this item).
Exh.	_____	Submit staff policy/provision for patients who received services at the hospital outpatient department and were admitted to the hospital as an inpatient within 72 hours.

Note: The below requirement (5g) only applies to off-campus hospital-based outpatient departments only. Place an X in this box and skip to step 5h if this does not apply to your facility:

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5g)	_____	When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than a RHC) that is not located on the main provider's campus, and the treatment is not required to be provided by the anti-dumping rules in 489.24 of Chapter IV of Title 42, the hospital provides 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's service, and an estimate of the amount of that liability).
5g.1)	_____	The notice is one that the beneficiary can read and understand. This should be on main hospital letterhead and include contact information.
Exh.	_____	Submit a copy of the notice given to patients that demonstrates compliance with section 5g thru 5g.2. The notice should state the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital. If the exact type of extent of care needed is not known, the notice must state that the beneficiary will incur a coinsurance liability to the hospital that beneficiary would not incur if the facility were not provider-based, and an estimate based on typical or average charges for visits to the facility with an explanation that the patient's actual liability will depend upon the actual services furnished by the hospital. If this does not apply to your facility (e.g. RHC, physical, speech, and occupational therapy, etc.) please document and explain this in your attestation. Note: The Advance Beneficiary Notice (ABN) forms are not acceptable.

5g.2) _____ If the exact type and extent of care needed is not known, the hospital furnishes a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that he/she would not incur if the facility were not provider-based, AND the hospital furnishes an actual amount or an estimate of the patient's liability based on typical or average charges for visits to the facility, but states that the patient's actual liability will depend upon the actual services furnished by the hospital.

Exh. _____ **Provide a copy of the potential charges used to complete the beneficiary coinsurance financial form.**

5g.3) _____ If the beneficiary is unconscious, under great duress, or for any other reason is unable to read a written notice and understand and act on his/her own rights, the notice is provided before the delivery of services, to the beneficiary's authorized representative.

Exh. _____ **Submit a staff policy/provision for the Medicare beneficiary financial liability form describing the staff actions for beneficiaries that are unconscious, under great duress or unable to read a written notice and understand and act on their own rights.**

5h) _____ Hospital outpatient departments meet applicable hospital health and safety rules for Medicare participating hospitals in Part 482 of this Chapter.

Exh. _____ **Submit document to support the outpatient department meets applicable hospital health and safety rules for Medicare participation.**

42 CFR 413.65(f): Provider-based Status for Joint Ventures:

If your facility is not operated as a joint venture, please enter an X in this box and skip to section C.

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For facilities/organizations operated as joint ventures requesting provider-based determinations: In addition to the above requirements and obligations (numbers 1 – 4, 5a-f, & 5h for on-campus facilities), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider:

Enter Y or N by the items below, as applicable:

6) _____ The facility or organization being attested to as provider-based is a joint venture that fulfills the following requirements:

6a) _____ The facility is partially owned by at least one provider;

6b) _____ The facility is located on the main campus of a provider who is partial owner;

6c) _____ The facility is provider-based to that one provider whose campus on which the facility or organization is located;

6d) _____ The facility or organization meets all the requirements applicable to all provider-based facilities and organizations in Section B, items 1-4, 5a-f, & 5h of this attestation.

Exh. _____ **Submit a copy of the joint venture agreement.**

If on page 6, you indicated the facility/organization is located **ON-CAMPUS** of the main provider and any responses to the above questions for "Joint Ventures" are "N" or "NO", the facility/organization **does not** qualify as a provider-based.

If on page 6, you indicated the facility/organization is located **ON-CAMPUS** of the main provider and all responses to the above questions for "Joint Ventures" are "Y" or "YES", complete Section D (Attestation/Signature page).

If on page 6, you indicated the facility/organization is located **OFF-CAMPUS** of the main provider, the facility/organization **does not** qualify as provider-based.

Joint Venture Additional Comments:

SECTION C. CRITERIA 413.65(e) Additional requirements applicable to off-campus facilities or organizations ONLY

Note: OFF-CAMPUS FACILITIES must complete the following items, in addition to Section B, parts 1-5.

If your facility is not an off-campus facility, place an X in this box and skip to Section D

Ownership and Control:

(Enter "Y" or "N" by each of the below items)

1) _____ The facility or organization seeking provider-based status is operating under the ownership and control of the main provider, as evidenced by the following:

1a) _____ The main provider and the facility or organization seeking status as a department of the provider, a remote location of a hospital, or a satellite facility have the same governing body.

Exh. _____ Submit copies of articles of incorporation, etc. and main provider's by-laws.

1b) _____ The facility or organization is operated under the same organizational documents as the main provider. For example, the facility or organization seeking provider-based status is subject to common bylaws and operating decisions of the governing body of the provider where it is based.

Exh. _____ Submit copies of provider-based articles of incorporation, etc. and provider-based by-laws. (If separate documents exists.)

1c) _____ The main provider has final responsibility for administrative decisions, 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 facility or organization.

Who has final approval for administrative decisions? _____

Who has final approval for personnel policies? _____

		Who has final approval for medical staff appointments?	
Exh.		Submit copy list of final approval for administrative decisions, personnel policies, and medical staff appointments. (If not provided above.)	
1d)		The business enterprise that constitutes the facility or organization is 100% owned by the provider.	
Exh.		If the provider based entity is operating in leased space, please provide a copy of the facility lease.	
Ownership and Control Additional Comments:			
Administration and Supervision:			
(Enter "Y" or "N" by each of the below items)			
2)		The reporting relationship between the facility or organization seeking provider-based status and the main provider has the same frequency, intensity and level of accountability that exists in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:	
2a)		The facility or organization is under direct supervision of the main provider.	
Exh.		Submit list of the key administrative staff (position/titles only) at the main provider and the facility that reflects a reporting relationship.	
2b)		The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability.	
The facility or organization director or individual responsible for daily operations at the entity:			
(Enter "Y" or "N" by each of the below items)			
2b.1)		Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity and level of accountability that exists in the relationship between the main provider and its existing departments; and	
Exh.		Provide a copy of the organization's organizational chart. The chart must include the main provider and the entity requesting provider-based status and show which department of the main provider the entity is included.	
2b.2)		Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.	
Exh.		Submit a written description of the facility director's reporting requirements and accountability procedures for day-to-day operation.	
2c)		The following administrative functions of the facility or organization are integrated with those of the main provider where the facility or organization is based:	
(Enter "Y" or "N" by each of the below items)			
2c.1)		Billing Services	
2c.2)		Records	

- 2c.3) _____ Human Resources
 2c.4) _____ Payroll
 2c.5) _____ Employee Benefit Package
 2c.6) _____ Salary Structure
 2c.7) _____ Purchasing Services

Place an "X" by how these administrative structures are integrated:

2c.8) _____ Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or,

2c.9) _____ The administrative functions for both the facility organization and the main provider are contracted out under the same contract agreement; or,

2c.10) _____ Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

Submit a list of various administrative functions at the facility/organization that are integrated with the main provider. Also, include copies of any contracts for administrative functions that are completed under arrangements for the main provider and/or facility/organization.

Exh. _____

Administration and Supervision Additional Comments:

Management Contracts: Complete this section only if the facility/organization is located off campus of the main provider and is operated under a management contract; otherwise record "N/A"

Place an X in this box if on-campus, or if management contracts are N/A

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3) _____ The facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirements of Licensure (Section B1), Clinical Services (Section B2(a-f)), Financial Integration (Section B3), Public Awareness (Section B4), Obligations of Hospital Outpatient Departments and Hospital Based Entity (Section B5(a-h)); Off-Campus- Ownership and Control (Section C1(a-e)), Administration and Supervision (Section C2), and Location (Section A1-5), but is operated under management contract, meets all of the following criteria.

The main provider (or an organization that also employs the staff of the main provider and that is not the management company) employs the staff of the facility or organization who are directly involved in the delivery of patient care, except for 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. Other than staff that may be paid under such a Medicare fee schedule, the main provider does not utilize the services of "leased" employees (that is, personnel who are actually employed by the management company but provide services for the provider under a staff leasing or similar agreement) that

3a) _____ are directly involved in the delivery of patient care.

The administrative functions for both the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph 2c) above.

3b) _____

The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph 2b) above.

3c) _____

The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

3d) _____

Exh. _____ Submit a copy of the management contract.

D. PROVIDER ATTESTATION/SIGNATURE:

I attest that the facility/organization complies with the above requirements to be provider-based to the main provider and that the responses in this attestation and information in the documents are accurate, complete, and current as of this date. I acknowledge that the regulations must be continually adhered to. Any material change in the relationship between the facility/organization and the main provider, such as a change of ownership or entry into a new or different management contract, will be reported to CMS.

Print Name: _____

Signature: _____

(Signature of Officer or Administrator or authorized person on PECOS)

Title: _____

(Title of authorized person acting on behalf of the provider)

Direct Phone Number: _____

Email Address: _____

Date: _____

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by a trick, scheme or device a material fact, makes any false, fictitious or fraudulent statement or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than \$10,000 or imprisoned not more than five years or both (18 U.S.C. Section 1001).

The provider must submit an original signed attestation to WPS. The provider must provide an exact copy to the appropriate Regional Office.

We ask that you use one cover letter, addressing the letter to WPS (original signed copy) and put as a courtesy copy to the appropriate Regional Office. This way both organizations are clear that you have provided both of us a copy and no sharing of information is necessary.