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Provider based billing in the United States: The effect on government reimbursement

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PROVIDER BASED BILLING IN THE US: THE EFFECT ON GOVERNMENT REIMBURSEMENTS

ABSTRACT

Introduction: Provider-based status has been a Medicare payment designation established by the Social Security Act that has allowed facilities to bill for the physician services based on facility type. Medicare reimbursement has been based on whether they were rendered at a free standing healthcare facility or a provider-based facility. PBB has been comprised of two separate charges from the outpatient department inclusive of a facility charge and a professional charge.

Methodology: The methodology for this study utilized a literature review. It consisted of academic sources, five electronic databases, academic journals, and government websites. Thirty- six sources were referenced for this literature review.

Results: The literature review illustrated examples of provider-based clinics whom have billed all Medicare patients as hospital outpatients to ensure that the claim has split correctly and resulted a charge for the provider and the facility. It was found that the reimbursement has been higher for hospitals that have implemented PBB.

Discussion/ Conclusion: PBB has reported to be the magnitude of increased Medicare and Medicaid reimbursements. It has required patients to pay higher copayments for office visits for the facility fee, but overall the providers have received higher reimbursement. The study reviewed limitations that included the search strategy such as distinguishing differences between

keywords, databases used, and publication bias. Practical implications included continual participation with Medicare, Medicaid, and hospitals to keep the Provider Based Billing up to date.

Key Words: Medicaid, Medicare, Provider Based Billing, Reimbursements, and Revenue Cycle.

INTRODUCTION

Provider-based status has been a Medicare payment designation established by the Social Security Act that has allowed facilities to bill for the physician services based on facility type; the Centers for Medicare and Medicaid Services (CMS) asserted provider-based facilities offered important potential benefits and have included but were not limited to increased beneficiary access and integration of care (Levinson, 2016). Medicare reimbursements have been based on whether they were rendered at free- standing health care facilities or a provider-based facility. (Electronic Code of Federal Regulations, 2018). Provider based billing (PBB) has been comprised of two separate charges from the outpatient department inclusive of a facility charge and professional charge (Cleveland Clinic, 2012). PBB has also been referred to as hospital-based billing meaning medical services were performed in an on-site hospital and operated by an outpatient clinic: an example of hospital-based billing has been when a patient has been seen in a hospital-based outpatient clinic and billed as if they were in the hospital and not a physician's office (Knoxville Hospital, 2018). As with any billing methodology, hospitals must meet specific guidelines to be eligible to bill Medicare for rendered services under provider-based designation (RRMC, 2018).

Medicare beneficiaries have been subject to increased financial liability in PBB settings in this case Medicare has reimbursed the fee associated with a physician visit charge but the beneficiary has the remaining portion of a claim, inclusive of the facility charge, deductible, and coinsurance (Bina & Marsyla, 2013). These locations have been required to be located at the main campus of a hospital or within 250 yards of the main hospital (Agrawal, 2015). This has often allowed patients to have received additional testing or procedures in accordance with

provider visits that have improved access and continuity of care (Ezeonwu, 2018). Balanced billing has been common in concierge medical practice, and when a patient has received care out of the network plan, it has been costlier for the patient (Davis, 2018). Provider-Based status has been described as the relationship between the main provider and provider-based entity that complies with the requirements for PBB (Looney & Gilley, 2013). Medicare Claims Processing have required the place of service to be indicated on a claim to determine the payment for services (CMS, 2017). Furthermore, CMS, 2010, described a provider-based entity as having been comprised of both the specific physical facility that serves as the site where the service was performed in which Medicare or Medicaid could claim payment and the personnel and equipment that was required to deliver the services. This has been necessary as a physician has been paid more for professional services rendered in their office rather than a hospital outpatient or ambulatory surgery center due to CMS, Medicare and Medicaid have only paid the facility charge and not the physician for the facility's overhead expense (Twiddy, 2015).

The revenue cycle has been defined as all the administrative and clinical functions and processes that have begun as soon as the patient comes into the system, which has contributed to the charge capture and management of patient service revenue (Healthcare Financial Management Association, 2010). The flow of the revenue cycle started at the scheduling and pre- registration, then has gone to point of service registration, encounter utilization, charge capture and coding, claim submission, third party follow-up, remittance processing and claim rejections, payment posting, appeals, and collections (Oregon Health and Science University, 2018). It has been shown the average 350 bed hospital has missed $22 million in revenue capture opportunities and has continued to worsen with net patient revenue decreased from 2011 to 2015 (Sanborn, 2017).

Provider-based clinics have had to strategically choose to bill the correct place of service for the claim to split correctly (Noridan, 2017). Locations have been part of the billing process: for example, when the hospital has owned space and providers have performed services, with all other stipulations met, it has been billed provider based (Mercy Health, 2018). Medicare and Medicaid patients have been the only patients that have been affected by PBB: The Joint Commission has closely monitored quality standards for the patients' billing processes for the facility and provider charges (The Joint Commission, 2010). Governmental claims have been paid with a Prospective Payment System (PPS), which has been made under a predetermined, fixed amount and has been used by (CMS) for acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities (CMS, 2018a).

Provider-based requirements have had specific advantages for Medicare and Medicaid payments, while disadvantages have included Medicare billing, Emergency Medical Treatment and Active Labor Act, commercial payers refusing to pay facility fees, and Medicare conditions of Participation for specific hospitals apply (CMS, 2012). The universal requirements for PBB have been to keep a common licensure with the state law financial integration, clinical integration, and public awareness (Tankersley, et. al., 2015). Rural Health Clinics (RHC) have been noted as clinics classified in a non-urbanized area to provide physician services that must employ a nurse practitioner or physician's assistant (CMS, 2018b).

The purpose of this research study was to evaluate the impact of the Provider Based Billing in the revenue cycle in hospitals and determine if it has increased Medicaid and Medicare reimbursements in the US.

METHODOLOGY

The primary hypothesis of this study was that Provider Based Billing has provided increased payments for rural clinics or hospitals that have implemented this process. The methodology for this research analysis was a qualitative study with mixed methodologies including a literature review following a systematic approach, academic sources, and a semi-structured interview with the Vice President of the Revenue Cycle from the Business Office at Holzer Health System. The interview was conducted on October 31, 2018. Furthermore, a semi-structured interview with the Vice President of the Revenue Cycle supplemented information to the data collected. The Vice President of the Revenue Cycle will be referred to as Expert in Revenue Cycle throughout the research study. The interview was face to face and IRB approval was obtained prior to execution.

The concentration for this research study followed the steps of a systematic approach. The conceptual framework of this research explains the use of PBB in hospital locations in an abundance of studies of heterogeneous quality. The research method, illustrated by Table 1, is an adaption of the framework by Mary Rutan Hospital showing the benefits and barriers to use of PBB with providers in hospitals. The use of this framework is appropriate because it portrays the importance of PBB with Medicare billing. Similar to any project development, this billing process has been circular as it began with identification and definition of the problems and includes development solutions to possible questions. In this case, the solution has been implementing PBB in the hospital locations for Medicare payments. Through process assessment, the use of PBB in Medicare billing is researched and the payments raise once it is implemented. Once hospital locations adopt the applications for PBB, barriers and benefits can be addressed (see Figure 1).

The literature review was conducted in three individual stages involving: (1) developing a search strategy and gathering data for the case study; (2) determining and analyzing the relevant literature; (3) delegating literature to appropriate categories.

Step 1: Literature Identification and Collection

The electronic databases used include Jamia, Elibrary, PubMed, Medline, and Google Scholar. The terms searched within each database were: "Revenue Cycle" AND "Provider Based Billing" OR "PBB," OR "Payments" OR "Reimbursements" AND "Medicare" OR "Medicaid" AND "Hospitals" AND "Rural Health Clinics." Journals cited included but were not limited to: The Journal of the Medical Library Association, The Journal for Nurse Practitioners, Journal of Cultural Diversities, Journal of American Health Information Management Association, and other reliable medical and government websites. The search identified 98 relevant citations and articles were excluded (N= 60) if they did not meet inclusion principles. Articles were included (N=36) if they described the effect of Provider Based Billing with governmental payments: articles from other sources (N=6) were also included in this search. These 36 references were subject to full-text review, and these 36 citations were included in the data abstraction and analysis. Only 14 references were used in the results section. (see Figure 2)

Step 2: Literature Analysis

As Provider Based Billing has continued to grow throughout hospitals, it has become important to acknowledge the impact on governmental payments. Therefore, the literature analyzed focused on the following key areas: governmental reimbursement with PBB in determining how things would be paid according to the place of service on the claim. In attempt

to collect the most recent data, only sources from 2008-2018 that were written in English were used. Primary and secondary data from articles, literature reviews, research studies, and reports written in the US were included in this research.

The literature search was conducted by VW and validated by AC, who acted as second reader and double checked if references met the research study inclusion criteria.

Step 3: Literature Categorization

The following subheadings were included in the research: Payments from Medicare and Medicaid, Freestanding Facility versus PBB Facility, and Importance of Billing with the Correct Place of Service.

RESULTS

Payments from Medicare and Medicaid

Medicare's combined fees that have been paid to hospital-based practices have been more than 50% greater than freestanding practices, and patients with insurance have paid copayments of $25 for office visits and 20% to 30% of the facility fee, which the insurance has categorized into "coinsurance payments" (ACP, 2013). Medicare beneficiaries have been required to cover copayments of 20% of the Medicare approved amount for Part B services in both freestanding and PBB facilities, therefore the patient has been responsible for higher copays in PBB locations versus freestanding facilities (Levison, 2016). It was also determined physicians in PBB locations were not always selecting the correct place-of-service codes for billing, which led to fraudulent charges estimated to be $9.5 million in overpaid Medicare claims (Levinson, 2016).

Nurse Practitioner (NP) claims have split charges with PBB when the service has been performed in an inpatient or outpatient hospital or emergency department has been used when both the NP and physician from the same specialty have both had face to face visits with the patient (Dillon & Hoyson, 2014).

Rural Health Clinics

RHCs have required a team approach in physicians working with NPs and other medical staff whom have provided services (Rural Health Information Hub, 2018). In essence, RHCs reported to receive special Medicare and Medicaid reimbursement because Medicare visits have been reimbursed based on allowable costs and Medicaid visits have been reimbursed under cost-based method or the alternative PPS (HRSA, 2011). The Henry Kaiser Family Foundation, 2017, extracted 4,177 total RHCs in the US. Medicare has reported to pay 80% of the RHC

encounter rate, leaving the patient with the balance of 20% for coinsurance (HRSA, 2011). RHC's billing guidelines have acknowledged duplicate visits and do not bill more than one practitioner with the same specialty unless an additional diagnosis or issue has been reported (CMS, 2018c).

The physician reimbursement for RHCs have had fee schedules for some services, and hospital reimbursement has been received for cost based reimbursement, productivity limits, cost per visit, and physician compensation allowable costs (Waltko, Chambers, & McGee-Waltko, 2006). The semi structured interview in 2018 reported Holzer in Gallipolis would financially benefit by not having PBB destinations (Expert in Revenue Cycle, 2018). Moreover, the expert noted Holzer has been a rural facility and has multiple billing systems, which has caused issues with excess work in the entire revenue cycle.

Freestanding facility versus PBB facility

Freestanding Emergency Departments (EDs) have been brought to attention through CMS, providers, and communities who have revealed the continued demand for ED services and crowded EDs (CMS, 2008). In another report, outpatient ED visits have increased from 2010 with 7.4% per capita to 13.6% in 2015 per capita and physician office visits have slightly increased from 1.9% to 3.5% per capita (MedPac, 2017). Furthermore, it was also reported that freestanding EDs have provided competition with on campus EDs because freestanding facilities do not bill PBB.

Table 1 portrayed the Medicare physician fee schedule and outpatient PPS for freestanding ED payment levels Type A, described as facilities open 24 hours a day, and Type B, facilities open fewer than 24 hours a day (Medpac, 2017). He, Hou, Tolo, Patrick, and Gerald, 2011, reported an increase in ED visits from 5,010,000 visits to 7,390,000 from 1998 to 2008

and Texans have used hospital based-EDs and urgent care centers more than free standing clinics, although freestanding ED utilization has increased 236% between 2012 and 2015. In addition, these authors confirmed a 75% overlap in the 20 most common diagnoses at the freestanding EDs and another 60% overlap in diagnoses for hospital-based EDs and urgent care centers. The average cost to treat a patient in a freestanding ER has been reported to be around $3,000 as opposed to $136 for the traditional doctor's office or at the urgent care center (Lopez, 2017).

Importance of Billing with the Correct Place of Service

CMS has required outpatient departments that were not located on the provider's main campus to provide written notice to the Medicare beneficiary before the delivery of services (ACP, 2013). Medicare fraud has been reported to be $33.4 million for incorrectly coded services from January 2010 to September 2012 when the physicians performed the services in a facility location but coded it incorrectly as a non-facility location (Levinson, 2015). Medicare reimbursement was identified in an incident to bill a place of service with an error because the physician was practicing in hospital owned clinics that had interfered with PBB (Hofstra & Hart, 2012).

The expert in the Revenue Cycle reported there has been an increase in facility payments with "split billing" implemented in facility and professional components separately. Costs associated with processing claims at Holzer Health System in Gallipolis, Ohio have increased because of the increased expenses to full-time employees used for post registration claims. Holzer has multiple billing systems, platforms, and interfaces, which has caused extra work for the process due to a lack of steady workflows (Expert in Revenue Cycle, 2018). It was

described by the expert, using PBB with one EMR and billing system would have been more strategic with split billing. It was also reported Medicaid claims processing has been the most challenging with the process of PBB because most Medicaid Health Maintenance Organization have not had complex billing platforms and the rules associated with PBB complicate their claims processing systems which has ended up impeding the revenue in the adjudication process.

DISCUSSION

The purpose of this research study was to evaluate the impact of the Provider Based Billing in the revenue cycle to determine if it has increased Medicare and Medicaid reimbursements in the US. The primary hypothesis of this study was that PBB have provided increased payments for hospitals that have implemented this process. The results of this literature review has suggested PBB has provided increased payments for hospitals that have implemented this process with the same billing systems on the facility and professional side of the hospital. The Expert in Revenue Cycle reported an opinion that described if the entire hospital has one billing system, PBB flowed more efficiently.

PBB has required patients with insurance to pay copayments for office visits and 20% to 30% of the facility fee, which the insurance categorizes into coinsurance payments (ACP, 2013). This agency also reported results with Medicare reimbursement and PBB have been 50% greater than freestanding practices. RHCs have determined different total costs by the services received divided by the allowable RHC visits. RHC's billing guidelines have acknowledged duplicate visits and do not bill more than one practitioner with the same specialty unless an additional diagnosis or issue has been reported (CMS, 2018c). Medpac 2017, reported

provider's incentive to treat Medicare patients in the ED because the payment has been higher than its total payment made to other hospital settings.

Dillon and Hoyson 2014, reported NP charges have split charges with PBB when the service has been performed in an outpatient or inpatient hospital or emergency department that has been used when both the NP and physician from the same specialty have had face to face visits with the patient the same day of service. CMS, 2016, determined the place of service has played a huge role in reimbursement throughout nursing homes, retail clinics, and registered inpatients versus outpatient charges. Levinson 2015, examined fraud to be $33.4 million for incorrectly coded services from January 2010 to September 2012 when the physician performed services in a facility location but was billed incorrectly as a non-facility location.

A positive component of PBB with Medicare has been the increase in provider reimbursement with the professional and facility charges being billed separately. A negative component to PBB implementation has been the excess of work and staff it has required to keep up with the charges. It can be costlier as it was noted in the interview because of the extra staff and programs it has enforced to be implemented in order to stay ahead with the charges splitting. It was reported that it has taken extra staff to make appointments and verify all of the charges have been split correctly.

Limitations

This research study was conducted with limitations. The research of the study conducted PBB increased payments with Medicare and Medicaid, but throughout the interview with the expert in the Revenue Cycle, reported PBB has cost Holzer more money with extra employees to do excess work. This literature review was restricted due to search strategy such as

distinguishing differences between keywords, number of databases accessed, or the sources used. In addition, research and publication bias was a limitation during this study.

Practical Implications

Continual implication of PBB facilities in different hospitals around the US will provide more data for the future. The increase in payment for physician office visits have given providers the incentive to see Medicare patients. Further research is needed for PBB implementation for Medicare and Medicaid payments and hospital and clinic implementation.

CONCLUSION

Participation in PBB throughout hospitals has shown an increase in payments with Medicare payments. This literature review suggested that PBB has increased Medicare reimbursement to providers.

SEMI-STRUCTURED INTERVIEW

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APPENDIX A

Questions Asked in Semi-Structured Interview of an Expert in Provider Based Billing

- When did Holzer start with PBB and what was the main goal when for the revenue cycle?
- Do you see an increase in payment with split billing? What is the financial rates that increased with PBB?
- Since Holzer is more of a rural hospital, do you think it is more beneficial to stay PBB?
- How many locations does Holzer have that are Provider Based?
- Do you seem to have more issues with Medicare or Medicaid payments?
- Is HMOs more of an issue for payment versus traditional Medicare and Medicaid?

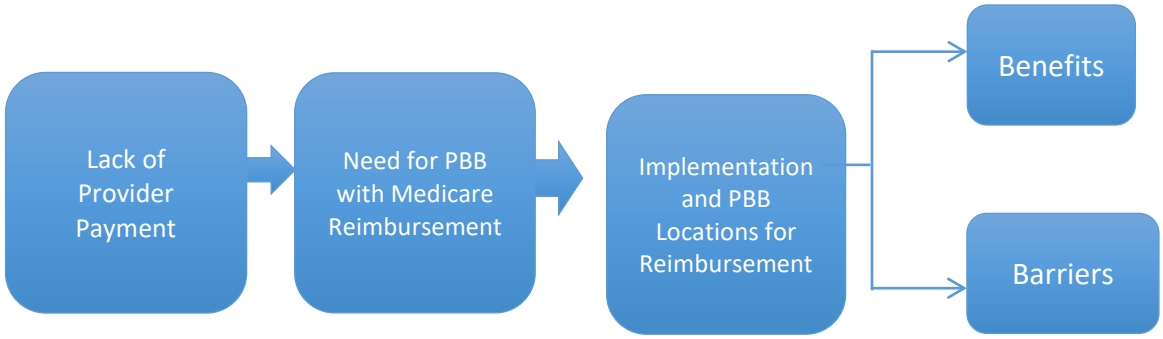

Figure 1. (Mary Rutan Hospital, 2018). "Conceptual Research Framework."

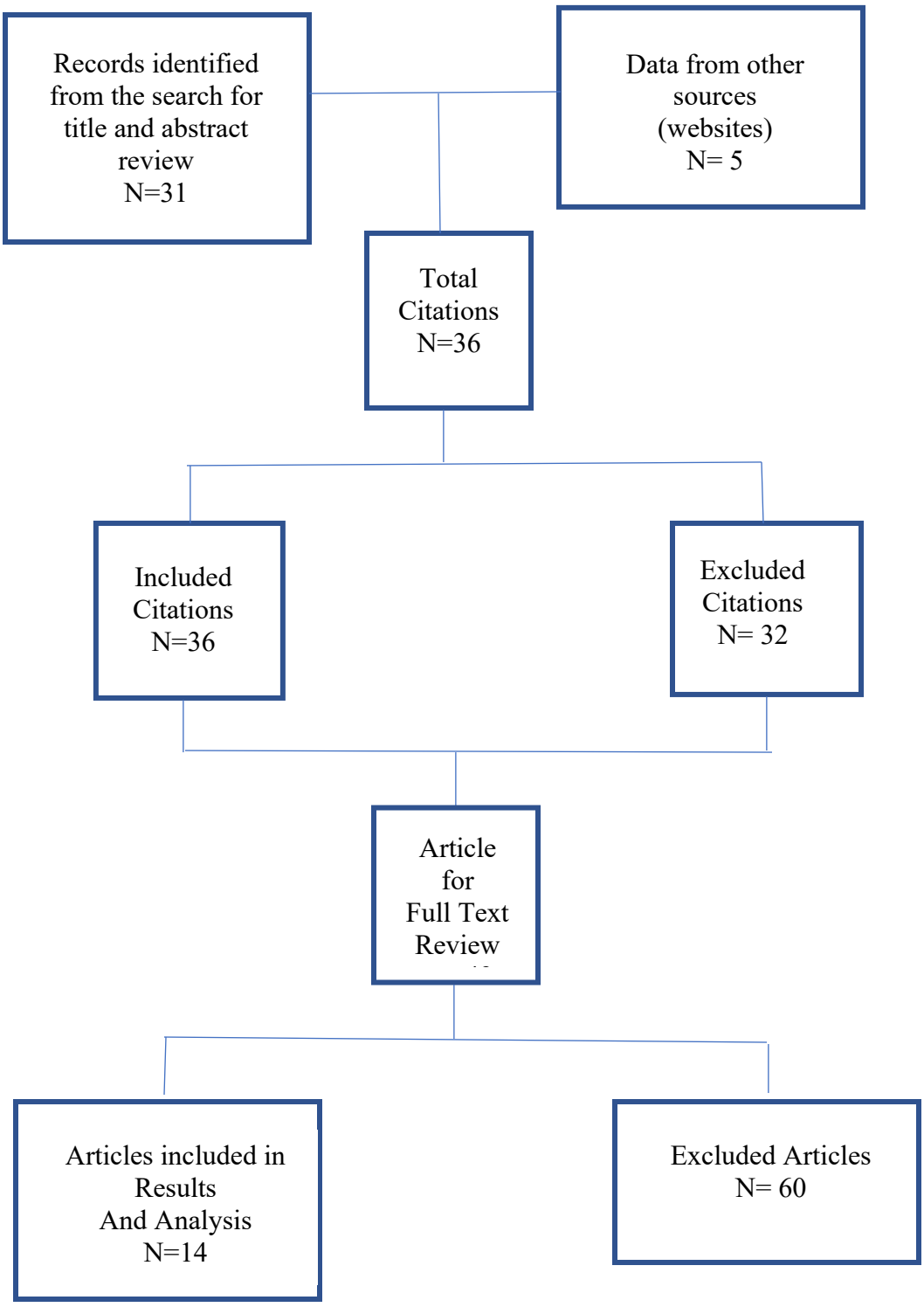

Figure 2. "Overview of Literature Evaluation"

Medicare Payments for ED Visits Under Medicare Fee Schedule and Outpatient Prospective Payment Systems

Emergency Department Payment Level	Physician Fee Schedule Payment for ED Visits	Type A ED Visit	Type B ED Visit
Level 1	$21.48	$59.30	$79.22
Level 2	$41.89	$109.51	$76.17
Level 3	$62.66	$195.98	$115.20
Level 4	$118.87	$326.99	$196.25
Level 5	$175.44	$486.04	$315.88

Table 1. (Medpac, 2017).