Palmetto GBA - JM
PROVIDER-BASED ATTESTATION STATEMENT

For a facility to be designated as provider-based for billing and payment purposes, it must meet the applicable requirements set forth by Centers for Medicare & Medicaid Services (CMS) in Title 42 Code of Federal Regulations (CFR) § 413.65. If you believe your facility meets the criteria as a provider- based facility, please submit the attestation statement to Palmetto GBA at the following address. In this statement, you must attest that the facility meets the relevant provider-based requirements of 42 CFR § 413.65.

Postal Service Address	Overnight Address
Palmetto GBA **JM Provider Reimbursement (AG-330)** **PO Box 100144** **Columbia, SC 29202-3144**	**Palmetto GBA** **JM Provider Reimbursement (AG-330)** **2300 Springdale Drive, Bldg. One** **Camden, SC 29020-1728**
Email for SC, NC, VA, WV locations	JMREIMBURSEMENT@palmettogba.com

Generally, the Medicare Administrative Contractor (MAC) will receive the attestation statement and any supporting documentation, review the statement for completeness and accuracy, and submit a recommendation to the CMS Regional Office (RO) based on the completed review. The CMS RO will review the MAC's recommendation and either approve or deny the recommendation. The CMS RO will notify the provider and the MAC of the decision regarding the facility's provider-based status.

Please note that provider-based determinations in relation to hospitals are not made for the provider types noted below. Refer to 42 CFR § 413.65(a)(1)(ii).

- Ambulatory Surgical Centers (ASCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Home Health Agencies (HHAs)
- Skilled Nursing Facilities (SNFs)
- Hospices
- Inpatient Rehabilitation Units that are excluded from the inpatient prospective payment system for acute hospital services
- Independent Diagnostic Testing Facilities furnishing only services paid under a fee schedule
- Facilities other than those operating as parts of CAHs that furnish only PT, OT, or ST to ambulatory patients during any period where the cap is suspended by regulation
- End Stage Renal Disease (ESRD) facilities
- 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
- Ambulances
- Rural Health clinics (RHCs) affiliated with hospitals having 50 or more beds

Note: A facility or organization may not qualify for provider-based status if all patient care services furnished at the facility or organization are furnished under arrangements as defined in Section 1861(w) of the Social Security Act.

The following is a form to use making the Provider-Based Attestation.

Provider-Based Status Attestation Statement

Section I: Attestation Information

Main Provider Name: _____

Provider Number. _____ NPI Number: _____

Main Provider Address: _____

_____

Attestation Contact Name (please print): _____

Phone Number: _____

Email Address: _____

Name of Applying Facility/Entity: _____

Address of Facility/Entity: _____

_____

Note: Facility names should reflect the advertised name of the facility. Addresses should include building number, suite/room number, etc., and be as precise as possible.

Facility/Entity Medicare Provider Number (if assigned): _____

NPI Number: _____

Services Performed by the Facility: _____

_____

Distance between Main Provider and Facility/Entity (in Yards or Miles): _____

Type of Facility/Entity (please check one):

_____ Provider-based entity
_____ Department of a provider
_____ Remote location of a hospital
_____ Satellite facility

Is the facility/entity part of a multi-campus hospital? _____Yes _____No

Is the facility/entity a Federally Qualified Health Center (FQHC)? _____Yes _____No

If so, 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.

The facility/organization became provider-based with the main provider on the following date:
_____/_____/_____

Type of Filing:

Initial attestation for this facility: _____Yes _____No
Updated attestation for this facility: _____Yes _____No
Effective date of changes: _____

In completing the attestation, please rely with "Yes" or "No" for each requirement or "NA" if not applicable.

Section II. Location of Provider

Indicate whether the facility/organization is "on campus" or "off campus (per §413.65(a)(2)) with the main provider:

_____ **On campus** of the main provider (located within 250 yards from the main provider building

_____**Off campus** of the main provider (located 250 yards or greater from the main provider building, but subject to §413.65(e)(3))

I certify that I have carefully read the noted 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 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (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 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.

For "on campus, skip to Section III.

OR

2.____ The facility/organization is "**off campus**" per 42 C.F.R. §413.65(a)(2) and is in compliance with the following provider-based requirements (shown in the following attached pages) in §413.65(d) and §413.65(e) 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 been met. Furthermore, I am **submitting** along with this attestation to the Centers for Medicare & Medicaid Services (CMS), the documentation showing the basis for these attestations (for each regulatory requirement).

I attest that the facility complies with the following requirements to be provider-based to the main provider.

Off Campus Requirements:

___The facility or organization is located within a 35-mile radius of the campus of the potential main provider, or meets the exception listed in (a) or (b) below.

a. ____ Disproportionate Share Adjustment: 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 percent or is described in §412.106(c)(2) of chapter IV of Title 42 implementing section 1886(e)(5)(F)(i)(ll) of the Act and is:

(1) _____ Owned and operated by a unit of State or local government; or

(2) _____ A public or nonprofit corporation that is formally granted governmental powers by a unit of State or local government; or

(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).

b. _____ High Level of Integration: The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the attestation for provider-based status is filed with CMS, and for each subsequent 12-month period:

(1)_____ At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider.

(2)_____ At least 75 percent of the patients served 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 least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(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 8b, 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 8b, accounted for at least 75 percent of the patients served by the main provider.

___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 <u>located in the same State</u> or, when consistent with the laws of both States, in adjacent States.

Note: An RHC that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area as defined in §412.62(f)(1)(iii) of chapter IV of Title 42, and has fewer than 50 beds as determined under §412.105(b) of chapter IV of Title 42, is not subject to the criteria in a and b above.

On campus locations - complete Sections III through VIII

Off campus locations - complete Sections III through XI

I attest that the facility/organization complies with the following requirements to be provider-based to the main provider (please indicate Yes or No for each requirement):

Section III: Licensure

_____ The department of the provider, the remote location of a hospital, or the 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. 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.

Section IV: Clinical Services

_____ The clinical services of the facility or organization seeking provider-based status and the main provider are integrated.

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

b._____ The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

c._____ The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the chief medical officer or other 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 other similar official 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.

d._____ Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization, 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.

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

f._____ Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization 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.

Section V: Financial Integration

_____ 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.

Section VI: Public Awareness

_____ 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.

Section VII: Hospital Outpatient Departments and Hospital-Based Entities

_____ In the case of a hospital outpatient department or hospital-based entity **(if the facility is not a hospital outpatient department or a hospital-based entity, please record "NA" for "not applicable")**, the facility or organization fulfills the obligations of:

a._____ Hospital outpatient departments located either on or off the campus of the hospital that is the main provider comply with the anti-dumping rules in §§489.20(l), (m), (q), and (r) and §489.24 of chapter IV of Title 42.

b._____ Physician services furnished in hospital outpatient departments or hospital-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.

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

d._____ 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.

e._____ Hospital outpatient departments (other than RHCs) treat all Medicare patients, for billing purposes, as hospital outpatients. The department do not treat some Medicare patients as hospital outpatients and others as physician office patients.

f._____ 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 hospital 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 CAH, enter "NA" for this item).

g.____ Off Campus Only – Beneficiary Notice
When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, and the treatment is not required to be provided by the antidumping 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 service, and of the amount of that liability).

(1) _____The notice is one that the beneficiary can read and understand.

(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 or she would not incur if the facility were not provider- based.

(3) _____ The hospital furnishes estimate 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.

(4) _____ 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 or her own rights, the notice is provided before the delivery of services, to the beneficiary's authorized representative.

(5) _____ In cases where a hospital outpatient department provides examination or treatment that is required to be provided by the antidumping 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.

h.____ Hospital outpatient departments meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

Section VIII: Joint Venture (On Campus Only)

For facilities/organizations operated as joint ventures requesting provider-based determinations: In addition to the above requirements (Sections III to VII for on campus facilities), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider:

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

a.____ The facility is partially owned by at least one provider;

b.____ The facility is located on the main campus of a provider who is a partial owner;
c.____ The facility is provider-based to that one provider whose campus on which the

facility organization is located; and

d.____ The facility or organization meets all the requirements applicable to all provider-based facilities and organizations in paragraph 1-5 of this attestation.

Off campus facilities also complete Sections IX to XI

Section IX: Operation Under Ownership and Control of Main Provider

____ The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

a.____ The business enterprise that constitutes the facility or organization s 100 percent owned by the provider.

b.____ 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.

c.____ 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.

d.____ The main provider 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 facility or organization.

Section X: Administration and Supervision

____ 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 exits in the relationship between the main provider and one of its existing departments, as evidenced by compliance with all of the following requirements:

a.____ The facility or organization is under the direct supervision of the main provider.

b.____ 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-

(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 department; and

(2) ____ Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

c._____The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group or employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are (1) contracted out under the same contract agreement; or (2) handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

Section XI: Management Contract

_____ The facility or organization that is not located on the campus of the potential main provider and otherwise meets the requirement of 1-8 above, but is operated under management contract, meets all the following criteria (**please respond a-d if the facility is operated under a management contract; otherwise record "NA" for "not applicable)**:

a._____ 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 provider services for the provider under a staff leasing or similar agreement) that are directly involved in the delivery of patient care.

b._____ The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph 7c above.

c._____ The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph 7b above.

d._____ 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.

Certification Statement

*** I certify 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 change of ownership or entry into a new or different management contract, may be reported to CMS. (NOTE: ORIGINAL ink signature must be submitted)**

Signed:_____
(Signature of Officer or Administrator or authorized person)

_____
(PRINT Name of signature)

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

_____
(Direct telephone number)

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 any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statement or representations, or make or uses any false writing or document knowing the same to contain ay 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 § 1001).**