Credentialing Resource Center Journal

Contingency planning: Comply with privileging requirements for provider-based locations

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Although CMS has now substantially limited the ability of a hospital to establish provider-based (PB) locations, they have been extremely popular over the past few years because they allow a hospital to bill for services as if they were provided at the main hospital building (i.e., each service generates both a facility fee and a professional fee).

To promote compliance with CMS' regulations surrounding PB designation, medical staff leaders, MSPs, and quality personnel must ensure all providers who practice at one or more of these locations are on the hospital's medical staff with clinical privileges specific to the given location(s). This process can be challenging for a number of reasons, including the following:

- Medical staffs have historically not engaged in peer review (e.g., OPPE and FPPE) for locations such as ambulatory care centers or urgent care centers; they have traditionally been more focused on procedures than on primary care
- Hospital quality departments have historically not needed to design screens for these types of care centers
- Medical staffs that already have a full plate may not appreciate having these additional care areas added to their responsibilities, especially when many of the providers who practice at PB locations may never step foot inside the main hospital
- Providers at PB locations are often employed by the hospital (or an affiliated facility)

Promoting ongoing regulatory compliance in the face of such challenges requires a proactive, not reactive, approach—that is, you need to consider not only the mechanics, but also the impact of a practitioner potentially having clinical privileges at more than one hospital location.

Nuts and bolts

When care is provided in the hospital setting, the term "hospital" includes both the main hospital building (the main provider) and all locations outside the main provider that have been designated as "provider-based." CMS permits institutional providers, such as hospitals and critical access hospitals, to apply this status if the main provider and designated PB locations meet all the elements of the provider-based rule.

Beyond the financial benefits mentioned previously, PB status can also benefit patients by ensuring their medical records are fully integrated. Realizing these advantages requires compliance with a detailed list of regulations.

A PB location is considered a department of the main provider and must therefore satisfy the same CMS *Conditions of Participation* as a hospital department located at the main provider. Otherwise, CMS may determine that the location in question is not part of the hospital, revoke its PB status, and seek to take back the difference in payment between a PB location and a freestanding location. This can be a significant financial problem for a hospital and can also result in loss of accreditation status at the location in question.

Given the systemic nature of these potential repercussions, it's important for everyone with a role in compliance to understand their hospital's stake in the PB designation. The easiest way to find out whether your hospital has any PB locations is to ask your chief financial officer.

Privileging requirements

Once stakeholders have assessed their hospital's PB locations, they can determine their role in upholding compliance. For MSPs and medical staff leaders, the PB rule's clinical integration element (§413.65 (d)(2)) is most central to their work. Among this provision's key focuses are the exercise, grant, and management of clinical privileges, including the following requirements:

- All practitioners who practice at a PB location must have an appointment to the hospital's medical staff with

clinical privileges applicable to that location
- These practitioners must be incorporated into the medical staff governing process
- These practitioners' clinical privileges must be subject to the same professional practice evaluation process as all other grants of clinical privileges

Location-specific practice issues

The PB rule's requirement of clinical integration can pose challenges when a practitioner exercises clinical privileges at both the main hospital building and a PB location. Imagine, for example, that Dr. Surgeon has two sets of clinical privileges with ABC Hospital. The first set corresponds to her surgery at the main provider, and the second corresponds to her outpatient clinic practice at a PB location. (Note that in non-PB locations, Dr. Surgeon's outpatient clinical practice would be called an office practice. However, for PB locations, which are considered hospital departments, there are only two options—inpatient or outpatient services.)

Dr. Surgeon's technical skills come under scrutiny in her main provider surgery practice when a number of her patients experience serious complications. However, no concerns emerge surrounding her outpatient clinic practice, which does not involve actual surgeries. Instead, at this location, Dr. Surgeon performs histories and physicals, treats patients with therapy and medications, and provides other nonsurgical care.

This disparity in performance can raise questions if Dr. Surgeon's surgical privileges at the main provider are suspended (either summarily or following a fair hearing process). Where does this leave her outpatient clinic practice? If there are no quality concerns at her outpatient clinic practice, how can you suspend those privileges? And if she is employed by the hospital (or an affiliated entity), does suspension of one set of privileges automatically result in suspension of a different set of privileges, or is the hospital now employing a surgeon who only has an office practice? Resolving such tensions is possible, but it requires effective contingency planning.

Relationship-specific contingency plans

If the practitioner is independent, you have the following options:

- Do nothing. The suspension of surgical privileges simply precludes Dr. Surgeon from practicing at the main provider. She will be able to continue her outpatient clinic practice, and, without the main provider's operating suite available to her, she may well resign her outpatient clinical privileges and relocate.
- Include language in the medical staff governing documents specifying that, if a practitioner's clinical privileges are terminated at the main provider, they will be automatically terminated at all PB locations. However, be careful with how you word this provision, as the practitioner's privileges may differ across locations. To cover this contingency, consider referring to the practitioner's appointment in addition to his or her privileges, as the following sample language does:

*"An automatic termination of **appointment and** clinical privileges at one Hospital location shall result in the automatic termination of clinical privileges at all other Hospital locations."*

One caveat: To avoid creating an unnecessary ripple effect on a practitioner's privileges and patients spanning hospital locations, only take this approach if you're clear about what hospital locations are provider-based. For example, Dr. Surgeon may do well at an ambulatory surgery center (due to the nonsurgical nature of her practice there), and so, although her main hospital privileges need to be terminated, her ambulatory surgery center privileges may not need to be.

If the practitioner is employed by the hospital or an affiliated entity, you have the options outlined previously, plus one more: Include language in the employment contract that covers location-specific privilege requirements. For example, the contract might specify that a surgeon must have clinical privileges at the main provider in order to maintain clinical privileges at a PB location, as the following sample provision provides:

"A baseline requirement of this Agreement is that, at all times during any term of this Agreement, the Physician must have unrestricted 'neurosurgery' privileges at the main Hospital in order to maintain his/her privileges at Physician's clinical practice."

Best practices for PB rule compliance

Regardless of a practitioner's relationship with the hospital, take the following steps to ensure compliance with the PB rule's provisions regarding credentialing and privileging:

- Ensure you can access all quality data (clinical and conduct) from the main provider and all PB locations when reviewing a practitioner. Because PB locations are considered hospital departments, MSPs and medical staff leaders must handle the peer review of a practitioner who practices at multiple PB locations in the same

manner as a practitioner who practices in both the operating room and the emergency department. You do not want to run into a situation where you fail to consider information relevant to your concerns.
- Share certain defined information during the course of an appointment/grant period. Imagine, for example, that Dr. Surgeon's main provider surgery practice is not raising issues, but her outpatient clinic practice shows a high post-surgery infection rate. Unless you have screens in place, you may fail to realize that these issues are linked and require joint consideration.
- Develop governing document language to deal with corrective action and automatic action issues. Consider, for example, what would happen if Dr. Surgeon's outpatient clinical privileges are summarily suspended. Does this result in an automatic suspension of her surgery privileges? Is the hospital at greater risk for a negligent credentialing claim if it permits Dr. Surgeon to continue to practice at other locations? Now imagine that Dr. Surgeon's clinical privileges at a PB outpatient surgery center are automatically suspended for failing to complete medical records timely. Does this suspension also apply to her outpatient clinical privileges at the main provider? Does it apply to her main provider inpatient clinical privileges?

Remember, one of the most critical steps in promoting ongoing compliance with the PB rule's credentialing and privileging provisions is knowing whether your hospital has any PB locations. Once you have this information, you can do what it takes to ensure not only that these locations are managed effectively from a privileging perspective, but also that the practitioners and advanced practice professionals who care for patients at these locations are incorporated appropriately into your medical staff and quality oversight processes.

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