Palmetto GBA
PROVIDER-BASED ATTESTATION STATEMENT

In order 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 **Provider Reimbursement (AG-330)** **PO Box 100144** **Columbia, SC 29202-3144**	**Palmetto GBA** **Provider Reimbursement (AG-330)** **2300 Springdale Drive, Bldg. One** **Camden, SC 29020-1728**

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. (An attestation statement is not needed for these types of facilities.)

- 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
- 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 Sample is intended to be a guide to assist you in the preparation of your Provider-Based Attestation. **All information within this Sample is required for a Provider-Based Determination.**

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

PROVIDER-BASED ATTESTATION STATEMENT

Main Provider's Medicare Provider Number: _____

Main Provider's Name: _____

Main Provider's Address: _____

Application Contact Name (please print): _____
Application Contact Phone Number: _____
Application Contact Email Address: _____

Facility/Organization's Name:_____

Facility/Organization's Exact Physical Address: _____
(including building/suite/room no., etc) _____

Facility/Organization's Medicare Provider Number, if there is one: _____

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

County that the Facility is located: _____

The Facility is considered to be either (please check one):

_____Remote location of a hospital
_____Satellite Facility
_____Hospital Outpatient Department

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

Is the facility 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:
_____/_____/_____
(Please indicate if this attestation is adding, deleting, or changing previous information-if yes, please make certain to include the effective date.)

Types of Services Performed by the Facility:

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

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

OR

2._____**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 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 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.

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).

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Please complete the following for on campus AND off campus facilities and organizations:

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):

1._____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.

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

2a._____Professional staff of the facility or organization have clinical privileges at the main provider.

2b._____The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

2c._____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.

2d._____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.

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

2f._____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.

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3._____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.

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.

5._____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" and skip to requirements under number 6)**, the facility or organization fulfills the obligations of:

5a._____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.

5b._____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.

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

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.

5e._____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.

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5f._____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).**

5g._____(**Note: This requirement only applies to off campus facilities**). 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 on 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.

5h._____Hospital outpatient departments meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

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For off campus facilities, please complete the following:

In addition to the above requirement (number 1-5h), I attest that the facility/organization complies with the following requirements to be provider-based to the main provider as an off campus facility (please indicate Yes or No for each requirement):

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

6a._____The business enterprise that constitutes the facility or organization s 100 percent owned by the provider.

6b._____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.

6c._____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.

6d._____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.

7._____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:

7a._____The facility or organization is under the direct supervision of the main provider.

7b._____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.

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7c._____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.

8._____The facility or organization is located within a 35-mile radius of the campus of the potential main provider, except when the requirements in paragraph 8a of this section are met (please check below in the appropriate location if you qualify for the exemption):

8a._____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;

(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).

8b._____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.

8c._____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.

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 8a and 8b above.

9._____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 of the following criteria (**please respond to 9a-9d if the facility is operated under a management contract; otherwise record "NA" for "not applicable)**:

9a._____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.

9b._____The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph 7c above.

9c._____The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph 7b above.

9d._____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.

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

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

10a._____The facility is partially owned by at least one provider;

10b._____The facility is located on the main campus of a provider who is a partial owner;

10c._____The facility is provider-based to that one provider who campus on which the facility organization is located; and

10d._____The facility or organization meets all the requirements applicable to all provider-based facilities and organizations in paragraph 1-5 of this attestation.

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OFF CAMPUS DOCUMENTATION CHECKLIST

Provider that wishes to obtain a determination of provider-based status for "off-campus" facility **must** submit the following documentation. The request cannot be processed without the appropriate documentation.

Licensure:
_____A copy of the State license, including the license number and the expiration date. Where applicable, submit documentation of whether the State where the entity is located requires a separate license for the facility requesting provider-based status.

Clinical Services:
_____A list of personnel working at the facility or organization showing their job titles and names of their employer.
_____Information as to whether professional staff of the facility have clinical privileges at the main provider.
_____Description of the level of monitoring and oversight of the facility by the main provider as compared to oversight for another department of the main provider.
_____Description of the responsibilities and relationships between the medical director of the facility, the chief medical officer of the main provider, and the medical staff committees at the main provider.
_____Written explanation of how medical records, for patients treated in the facility, are integrated into a unified retrieval system (cross-referenced) of the main provider.
_____Information on 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.

Financial Integration:
_____A copy of the appropriate section of the main provider's chart of accounts or trial balance that shows the location of the facility's revenues and expenses.

Public Awareness:
_____Include examples that show the facility is clearly identified as part of the main provider (i.e., shared name, patient registration forms, letterheads, advertisements, signage, Web site).
Note: Advertisements that show the facility to be part of or affiliated with the main provider's network or healthcare system are not sufficient. This does not apply of RHCs.
_____A picture of the exterior sign of the facility.

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OFF CAMPUS DOCUMENTATION CHECKLIST (continued)

Obligations of Hospital Outpatient Departments and Hospital-Based Entities:
_____A copy of the EMTALA policy in place at the facility.
_____Provide an example of the written notification that is provided to Medicare beneficiaries prior to the delivery of services, that states the amount of the beneficiary's potential liability (of the fact that the beneficiary will incur a coinsurance liability from an outpatient visit to the hospital as well as for the physician service, and of the amount of the liability). The notice must be one the beneficiary can read and understand. An advance beneficiary notice (ABN) for non-covered services doe not meet the requirement of providing written notice of beneficiary liability.

Provider-based Status for Joint Ventures:
_____For joint venture, submit documentation identifying the participants in the joint venture. Also submit support that verifies that the facility is located on the campus of the owning party of the venture to which provider-based status is being claimed.

Operation Under the Ownership and Control of the Main Provider:
_____Articles of incorporation and the bylaws for both the main provider and the facility.
_____Describe who has final approval for administrative decisions, contracts with outside parties, personnel policies, and medical staff appointments for the facility.

Administration and Supervision:
_____List of key administrative staff (position/titles only) at the main provider and the facility that reflects a reporting relationship.
_____An organization chart that includes the main provider and the facility requesting provider-based status.
_____A written description of the facility director's reporting requirements and accountability procedures for day to day operations.
_____A list of the various administrative functions (e.g., billing services, laundry, payroll) at the facility 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.

Location:
_____A detailed map to verify the distance from the main provider to the entity seeking provider-based status. An online service such as Mapquest may be use.

Management Contracts:
_____A copy of any relevant management contracts for the facility.

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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 ay 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).**