

AMBULATORY SERVICES

By Ellen V. Weissman
Hodgson Russ LLP
eweissman@hodgsonruss.com
www.hodgsonruss.com
1-800-724-5184

I. OVERVIEW

A. Introduction

1. Keeping abreast of changes in reimbursement rules is critical, since such changes may require a change in structure – either as a compliance issue or because the current structure may no longer be financially feasible.
2. In selecting an appropriate structure for a client’s proposed services, understanding reimbursement consequences is important. Projecting the likely *payor mix* is also important in selecting structure, since each payor may use a different reimbursement methodology.
3. Government payors (Medicaid and Medicare) are constantly revising reimbursement regulations to take account of changes in costs, utilization patterns, new technology, and to adjust for adverse consequences caused by the prior reimbursement methodology.
4. If you are representing a client in an audit or a rate appeal, it is important to focus on which years are the subject of the audit or appeal, since the reimbursement rules change frequently. Be sure you are researching (and any auditor is applying) the statutes, regulations, and provider manuals applicable to the period being audited or appealed.
5. The New York Department of Health (“DOH”), which is the state agency responsible for the Medicaid program, has proposed shifting Medicaid reimbursement dollars from inpatient to ambulatory services, by changing the methodology for reimbursing for outpatient services across a number of ambulatory settings and enhancing outpatient payment rates. This is designed to encourage use of ambulatory services instead of more costly inpatient services, and to address equity and access problems created by a history of underpaying for ambulatory care (i.e. capped and frozen

rates). DOH has proposed and begun implementing changes in reimbursement methodology designed to lessen the differentials that have existed in reimbursement across ambulatory settings based on licensure and site of service. For a history of the different reimbursement methodologies that existed before this recent initiative, see a paper prepared for the Medicaid Institute at the United Hospital Fund by Deborah Bachrach (and others) before she became Director of the Office of Health Insurance Policy (“OHIP”) at DOH:

http://www.uhfnyc.org/usr_doc/Administration_of_Medicaid_in_New_York_State.pdf.

6. Nonetheless, differences in reimbursement continue to exist based on licensure, site of service, and payor mix. This outline is intended to be an introduction to such differences in reimbursement, as well as significant changes initiated by government payors.

B. Structuring Alternatives under New York Law

1. Hospital Outpatient Clinic
2. Freestanding Clinic
3. Physician Office

C. Regulatory Consequences

1. Approvals Required? If so, from which agency or agencies?
2. Regulatory Constraints?
 - a. Construction
 - b. Operation

D. Reimbursement Consequences

1. Medicaid
 - a. Fee-for-Service (“FFS”)
 - b. Managed Care
2. Medicare
 - a. Fee-for-Service (“FFS”)
 - b. Managed Care
3. Commercial Payors/Managed Care

II. HOSPITAL OUTPATIENT CLINIC

A. Structure/Regulatory Approvals

1. Wholly owned by hospital (i.e. owned by the same corporate entity licensed to operate the hospital, and operated as part of the hospital). Public Health Law § 2801(1) and (10). This outline will cover clinics operated by hospitals approved under Article 28 of the Public Health Law, not hospitals approved under Article 31 of the Mental Hygiene Law.
2. Must get CON approval to add each location to hospital's NY operating certificate. Public Health Law § 2802; 10 N.Y.C.R.R. Parts 709 and 710.
3. Must meet hospital codes for construction and operation of each clinic site. 10 N.Y.C.R.R. Parts 709 and 710 (construction) and Part 405 (operation).

B. Reimbursement

1. Medicaid FFS

a. *Before 12/1/08:*

i. General Hospital Clinics:

Legal Authority: Public Health Law § 2807(2)(g)(i); 10 N.Y.C.R.R. § 86-1.11(h)(1) and Parts 441 and 446.

Rate Methodology: *Cost-based rate* calculated as follows:

Operating Costs: The operating component of the rate is calculated as a cost per visit, using allowable costs from a *base year* which is two years prior to the rate year. Since 1991, the operating component of the rate has been subject to a legislative cap of \$67.50 per visit. Most hospitals' costs have significantly exceeded this cap for many years.

Physician Services: The operating component of the rate can *include or exclude* the cost of physician services to staff the clinic, depending upon whether a hospital claimed such costs on its cost report in the cost reporting period two years before the rate year.

Ancillary Services: The operating component of the rate includes certain ancillary services, such as lab and x-ray services performed on the *same day* as a clinic visit that are related to the visit.

Recent Legal Issue: In 2008, the New York State Office of Medicaid Inspector General (“OMIG”) began an audit of general hospital clinics in which it alleged that additional ancillary services were included in the clinic rate and could not be billed separately. OMIG has suspended this audit while it is reviewing applicable law. The NYSBA Health Law Section website contains a lengthy letter to OMIG with citations addressing these issues:

http://www.nysba.org/AM/Template.cfm?Section=Payment_and_Reimbursement&Template=/CM/ContentDisplay.cfm&ContentID=22380

Capital Costs: are reimbursed on a pass through basis using allowable *rate year* costs.

- ii. AIDS/HIV Clinics. 10 N.Y.C.R.R. §§ 86-1.11(h)(2) and 86-4.35.
 - iii. Prenatal Care Assistance Program (“PCAP”): L. 1989, c. 584; 10 N.Y.C.R.R. §§ 86-1.11(h)(3) and 86-4.36.
 - iv. Preferred Primary Care Provider Program: Public Health Law § 2807(2)(h); 10 N.Y.C.R.R. §§ 86-1.11(h)(4) and 86-4.37.
- b. *After 12/1/08:* Ambulatory Patient Groups (“APGs”)

Legal Authority:

- Public Health Law § 2807(2-a)(e) enacted by L. 2008, c. 58, Part C, § 18;

- 10 N.Y.C.R.R. Part 86-8, adopted by NYS Register 12/3/08;

- Provider Manual link on DOH webpage:

http://www.health.state.ny.us/health_care/medicaid/rates/apg/

Rate Methodology:

- i. Operating Costs
 - (a) Base Rates: DOH has developed a separate base rate for (i) upstate/downstate providers and (ii) each type of service (hospital outpatient clinic services, hospital emergency department services, hospital ambulatory surgery services, freestanding clinic services, freestanding ambulatory surgery services) to recognize the difference in cost structure of each setting.
 - (b) Multiply the appropriate base rate times the “weight” associated with the APG classification assigned to each visit, after adjusting for “consolidating,” “discounting,” and “packaging.” Each weight reflects the relative resource utilization for a given APG. DOH has assigned a higher weight, leading to a greater payment, for higher cost, more intensive services.
 - (c) Key Definitions (10 N.Y.C.R.R. § 86-1.2):
 - (i) APGs are a patient classification system for encounters, procedures and ancillary services designed to reflect the resources used in an ambulatory visit. Certain non-routine ancillary services, such as MRI, are assigned their own APG.
 - (ii) Consolidating: Multiple procedures during a single patient visit are bundled into a single payment amount.
 - (iii) Discounting: Reduction in payment for multiple procedures or non-routine ancillary services performed during a single visit.
 - (iv) Packaging: Payment for *routine* ancillary services (such as x-ray and lab services) or drugs are deemed included in the APG payment for a related significant procedure or medical visit.

- (v) Visit: A unit of service consisting of all APG services for one patient on *one day*.
- (d) Add-On to the rate for: extended hours on evenings, weekends, holidays. 10 N.Y.C.R.R. § 86-8.12.
- (e) Four year transition period with a blended rate: blending the APG rate with the average payment per claim to that hospital in 2007 under the old rate.
- (f) Excluded Services (10 N.Y.C.R.R. § 86-8.10):
 - (i) Drugs
 - (ii) Visits solely for ordered ambulatory
 - (iii) Group or Offsite visits
 - (iv) Other
- (g) Physician services (and Ancillary Services) are *not* on the list of excluded services.

DOH position: A hospital clinic may continue its current practice with respect to physician services. If a hospital had included physician costs on its cost report and billed an “all-inclusive” clinic rate in the past, it may continue to do so under APGs, and the physicians may not bill separately. *See* Section 4.1 of the DOH APG Provider Manual listed on APG webpage cited above.

CMS Final Rule: On November 7, 2008, CMS adopted a regulation defining “hospital outpatient services” for Medicaid which could be interpreted to require DOH to exclude physician services (as well as clinical laboratory services) from the hospital outpatient clinic rate because the CMS regulation requires states to adopt Medicaid plans defining “outpatient hospital services” for Medicaid the same as Medicare. Moreover, if a state has a separate benefit coverage category for a service (such as physician or clinical laboratory services) it must cover and pay for that service under the separate benefit category. *See* 73 Fed. Reg. 66187 (11/7/08).

CMS Approval of APG State Plan Amendment: On December 16, 2008, CMS approved the NY Medicaid State Plan amendment on APGs for hospital outpatient clinics and emergency departments.

Legal Issue: Did CMS waive the November 7, 2008 regulations in approving the APG methodology?

Legal Issue: Since certain routine lab and radiology services are packaged into the APG rate, providers must enter into contracts with outside vendors to arrange for such services if they cannot render them directly, and the outside supplier of the service is barred from billing Medicaid directly for the service.

- ii. Capital Costs. No change from the prior methodology. Add-on to the rate using rate year allowable costs. 10 N.Y.C.R.R. § 86-8.4.
- iii. APG Methodology does not apply to:
 - (a) Enrollees in Medicaid Managed Care or Family Health Plus
 - (b) Facilities located outside NY state
 - (c) Services “not provided pursuant to a facility’s licensure under article 28 of the public health law.” 10 N.Y.C.R.R. § 86-8.1(b).

2. Medicare

- a. *If meet* the provider-based rules (42 C.F.R. § 413.65; CMS Program Memo A-03-030 (4/18/03)):
 - i. Reimbursed for *facility services* under Medicare hospital outpatient prospective payment system (“OPPS”). Social Security Act § 1833(t), 42 U.S.C. § 1395l(t); 42 C.F.R. Part 419. This methodology was first implemented effective 8/1/00. *See* 65 Fed. Reg. 18434 (4/7/00).
 - ii. OPSS is a prospective payment reimbursement methodology based on Ambulatory Payment Classifications (“APCs”). Services included in the OPSS rate are classified into an APC. Each APC is assigned a weight designed to account for relative

- use of resources/service intensity. A hospital may be paid for more than one APC per visit.
- iii. Wage Adjustment: Each APC is adjusted to reflect wage differences by geographic area.
 - iv. Services *included* in the OPSS facility fee are listed in 42 C.F.R. § 419.21.
 - v. Services *excluded* from the OPSS facility fee are listed in 42 C.F.R. § 419.22, such as:
 - (a) Physician professional services, which are reimbursed separately under the Medicare Physician Fee Schedule
 - (b) Other professional services such as: services of Nurse Practitioners, physician assistants, psychologists, clinical social workers
 - (c) Clinical diagnostic laboratory services
 - (d) Ambulance services
 - (e) Prosthetic devices/supplies and orthotic devices, with exceptions
 - (f) DME supplied for the patient to take home
 - vi. Co Payments: Patient receives two bills, one from the hospital for the facility fee, and a second from the physician for the professional fee. Patient has two co-pays. OPSS rules contain limits on co-payments.
 - vii. Recent changes in OPSS: 73 Fed. Reg. 68502 (11/18/08)
 - viii. Helpful website:
http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp;
 - ix. Comparison of NY Medicaid APGs to Medicare APCs, see page 11 of:
http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/apg_presentation.pdf

- b. If *not* meet provider-based rules:

Reimbursed as a physician office under the Medicare Physician Fee Schedule. No facility fee. Single bill to patient with one co-payment.

3. Commercial/Managed Care

- a. Participating Provider (Contract with Payor)
 - i. Contract terms govern reimbursement,
 - ii. *Unless* DOH, NYSID, Medicaid managed care (42 C.F.R. Part 438; 18 N.Y.C.R.R. Subpart 360-10) or

- Medicare managed care (42 C.F.R. Part 422) statutes or regulations provide otherwise.
- iii. *See also* DOH regulations and guidelines governing clauses that must be included and may not be included in contracts with providers and IPAs. 10 NYCRR Part 98, § 98-1.5.
 - b. Non-Participating Provider (No contract)
 - i. Bill charges to patients, subject to charitable/financial aid policies and any government regulations limiting charges.

Medicaid Managed Care: In some cases, Medicaid regulations prescribe the Medicaid FFS rates as a default rate for non-participating providers.

- ii. Can seek to negotiate contract with payor relating to individual patients.

III. FREESTANDING CLINIC

A. Structure/Regulatory Approvals

- 1. Create new entity which qualifies for approval as either a:
 - a. Diagnostic and/or treatment center (“DTC”) under Public Health Law Article 28 (Public Health Law § 2801(1); 10 N.Y.C.R.R. § 751.1).
 - i. DTC - 10 N.Y.C.R.R. Part 751
 - (a) General Clinic
 - (b) Specialty Clinics, such as
 - (i) DTC which is also an end stage renal disease (“ESRD”) facility under Medicare. 42 C.F.R. Part 413.
 - (ii) DTC which is also a comprehensive outpatient rehabilitation facility (“CORF”) under Medicare. 42 C.F.R. Part 485, Subpart B.
 - (iii) DTC which is also a federally qualified health care center (“FQHC”) under Medicare (*See* Section VI, below)
 - (iv) DTC which is also an IDTF under Medicare (*See* Section VII, below)
 - ii. Upgraded DTC - 10 N.Y.C.R.R. Part 752-2
 - iii. Ambulatory Surgery Center (“ASC”) - 10 N.Y.C.R.R. Part 755 (*See* Section V, below.)

- b. Clinic under Mental Hygiene Law Article 31 – (Not covered in this outline. *See* session on OMH facility reimbursement)
 - c. Clinic under Mental Hygiene Law Article 16 – (Not covered in this outline. *See* session on OMRDD facility reimbursement)
2. If creating new DTC, must get:
 - a. “Establishment” approval of the entity that will become the licensed operator. Public Health Law § 2801-a; 10 N.Y.C.R.R. Part 600. Criteria for Approval: Public Health Law § 2801-a(3); 10 N.Y.C.R.R. § 600.2. Note – there are limits on the types of entities that qualify as licensed operators of an article 28 clinic.
 - b. “Construction” approval for each location. Public Health Law § 2802; 10 N.Y.C.R.R. Parts 709 and 710. Criteria for Approval: Public Health Law § 2802(2)(b) and (3).
 - c. Types of entities that qualify for approval include: not-for-profit corporations, as well as limited liability companies and for-profit corporations owned by natural individuals.
 3. Must meet codes for construction and operation of each DTC site (10 N.Y.C.R.R. Part 750 et seq.)
 4. DTC owners may include a hospital and physicians, subject to compliance with all applicable laws, such as the federal Anti-kickback law (42 U.S.C. § 1320a; Social Security Act § 1128B; 42 C.F.R. § 1001.952), the Stark Law (42 U.S.C. § 1395nn; Social Security Act § 1877; 42 C.F.R. §§ 411.350-411.389), the NY Anti-kickback law (NY Social Services Law § 366-d), and the NY Practitioner Self-Referral Law (NY Pub. Health Law §§ 238-238-e).

B. Reimbursement

1. Medicaid FFS

- a. *Before 3/1/09* (10 N.Y.C.R.R. Part 86-4):

Summary: Although there is no statutory cap on this cost/visit rate, the rates have been frozen since 1995. L. 1995, c. 81, § 4, as most recently amended by L. 2007, c. 58, § 76. Generally, the DTC rates have been higher than the rates for general hospital outpatient clinics, which have been legislatively capped since 1991 at \$67.50. As a result, some hospitals have sought to spin off their

hospital clinics into DTCs to obtain a higher rate, particularly DTCs that will qualify as an FQHC. (*See* Section VI, below).

Operating Cost Component. DTCs that are not Federally Qualified Health Centers (FQHCs) or Ambulatory Surgery Centers (ASCs) are currently reimbursed for their operating costs using a rate calculated by dividing allowable base year costs by allowable base year visits, subject to a cap determined using “peer group” costs. Each DTC is assigned to a “peer group” of like facilities. The allowable operating costs for each DTC is capped using the average peer group base year cost. The base year is two years prior to each rate year (i.e. the methodology uses a rolling base year). However, since the rates for existing DTCs have been frozen since 1995, the rolling base year has little impact on the actual rate for an existing facility.

Capital Cost Component. Like hospital outpatient clinics, DTCs have a capital component added to their rate which is a pass-through based on allowable *rate year* costs.

The rate (composed of the operating component plus the capital component, with other adjustments not discussed here) is payable to the DTC each time a patient incurs a “threshold visit.” Certain types of visits do not count as threshold visits and have been the subject of audits (*e.g.* social work visits). There can be only one threshold visit per DTC per day. 10 N.Y.C.R.R. § 86-4.9.

b. *After 3/1/09:*

Medicaid will reimburse based on Ambulatory Patient Groups (“APGs”) *if CMS approves* the State Plan Amendment relating to DTCs. 10 N.Y.C.R.R. Part 86-8, adopted NYS Register 12/3/08.

Description of APG methodology: *See* description of APGs under Hospital Outpatient Clinics. In addition:

- i. Different base rate for: DTCs and ASCs
- ii. Different effective date from hospital clinics: with APGs effective for DTCs on 3/1/09
- iii. Physicians may not bill separately because physician services are included in the base rate. *See* APG Provider Manual § 4.1.

Legal Issue: DTCs will need to contract for physician services, and the contract should bar the physicians from billing separately. (The opposite is true for Emergency Department services.) *See* DOH APG Provider Manual § 4.1

- iv. APGs will *not* apply to:
 - (a) FQHCs unless they elect to have APG methodology apply
 - (b) Mental Hygiene clinics
 - (c) Other Medicaid Managed Care carve-out services (school-based clinics)
 - (d) Ordered Ambulatory Services

2. Medicare

- a. Reimbursed as physician office under the Medicare physician fee schedule *unless* certified as:
 - b. Ambulatory Surgery Center (“ASC”) – *See* Section V
 - c. Federally Qualified Health Center (“FQHC”) – *See* Section VI, below
 - d. Rural Health Clinic (“RHC”) – *See* Section VI, below
 - e. An ESRD facility under 42 C.F.R. Part 413
 - f. a Comprehensive Outpatient Rehabilitation Facility (“CORF”) under 42 C.F.R. Part 485, Subpart B.

3. Commercial/Managed Care

- a. Participating Provider

Contract terms govern reimbursement: Many payors will reimburse like a physician office and refuse to pay a facility fee. All a matter of negotiation.

- b. Non-Participating Provider (No contract)

Bill charges to patients, subject to any government regulations or charitable/financial aid policies

IV. PHYSICIAN OFFICE

A. Structure/Regulatory Approvals

1. Structure as either a:

- a. Sole Proprietorship
- b. Partnership
- c. Professional Services Corporation (“PC”) – NY Business Corporation Law Article 15
- d. Professional Limited Liability Company (“PLLC”) - NY Limited Liability Company Law Article 12

- e. University Faculty Practice Corporation (“UFPC”) – NY Not-For-Profit Corporation Law § 1412
All of the above can be owned only by licensed physicians.
- 2. NY Education Department must confirm physician owner licensure and consent to formation. Limitations on names that can be used for physician office entities. Recommend not using a name such as “Center” or “Clinic.” *See* 10 N.Y.C.R.R. § 600.8.
- 3. No establishment or CON approval – as long as truly a physician office and not a DTC (*See* 10 N.Y.C.R.R. § 600.8) No DOH provisions governing construction or operation of office except:
 - a. Office-based surgery limitations (Public Health Law §§ 230-d and 2998-e effective July 14, 2008); DOH website: http://www.health.state.ny.us/professionals/office-based_surgery/index.htm
 - b. Regulations governing public health issues such as construction standards for x-ray/MRI areas

B. Reimbursement

- 1. Medicaid FFS: Medicaid Physician Fee Schedule (www.emedny.org)
 - a. Severely underpaid in the past, leading to access problems. When not enough physicians are enrolled in Medicaid, patients use hospital emergency rooms. DOH is seeking to address this problem by increasing rates.
 - b. Site of service differential: Office setting vs. Hospital or freestanding clinic setting
- 2. Medicare FFS
 - a. *Before* 1991: Reimbursed based on the lower of three types of charges (Note - some commercial payors still use this structure):
 - i. Actual charge – the charge the physician actually bills for the particular service to a patient on a particular date
 - ii. Usual charge - the charge the physician usually bills for the particular service
 - iii. Customary charge – the charge most physicians in the area charge for this particular service

b. *After 1991: Medicare Physician Fee Schedule (“MPFS”).* Physicians continue to be paid on a fee-for-service basis, however the fees are computed on the basis of a fee schedule instead of physician charges. Under this fee schedule, each diagnostic code is assigned a different relative value unit (“RVU”). In addition, for each diagnostic code, the total RVUs are divided among services that compose the professional component (“physician work”) and those that compose the technical component (“practice expense”). The final rule for FY 2009 on the MPFS changes the calculation of the RVUs for the “practice expense” from a methodology based on historical charges to one based on relative resource use. 73 Fed. Reg. 69726, 69731 (11/19/08).

c. Site of service differential/Site of service coding:

- i. Differential: For services that can be performed either in a hospital outpatient setting or a physician office, Medicare pays a higher amount to physicians who perform the service in an office setting because CMS assumes that the physician is bearing the overhead, incurring higher costs, and therefore should be reimbursed for those overhead costs.
- ii. *Legal Issue:* A key compliance issue is to be sure that physicians use the correct coding for site of service (physician office vs hospital outpatient). Indeed, the provider-based rules applicable to hospital outpatient departments require, as one of the hospital’s obligations, to assure that the physicians who perform services at a hospital provider-based site use the correct site of service. See 42 C.F.R. § 413.65(g).

d. Limits on Reimbursement Amount for Diagnostic Tests:

- i. Cap Based on OPPS: After the Deficit Reduction Act of 2005, payment for certain diagnostic tests under the Medicare Physician Fee Schedule was capped at the amount payable under OPPS. Prior to enactment of this statute, payment for certain diagnostic tests under the Medicare Physician Fee Schedule exceeded reimbursement under OPPS.
- ii. Multiple Imaging Procedure Payment Reduction: Effective 1/1/06, there is a 25% reduction in Medicare payment for a second imaging test in certain circumstances. 70 Fed. Reg. 70115, 70261 and Table 27 (11/21/05).

- e. Anti-Mark-up Rule (Purchased Diagnostic Testing Rule):
42 U.S.C. § 1395u(n); SSA § 1842(n); 42 C.F.R. § 414.50(b).
- i. *Before 1/1/08:* If a physician or physician group “purchased” the technical component of a diagnostic test (not including clinical lab tests) and billed for it, Medicare would pay the lower of:
- (a) The amount charged by the supplier who performed the test or
 - (b) the reasonable charge of the supplier
- ii. *Effective 1/1/09,* CMS revised this rule as part of the FY 2009 Medicare Physician Fee Schedule. 73 Fed. Reg. 69726, 69793 (11/19/08).
- (a) Scope: Under the final rule for FY 2009, a diagnostic test is subject to the anti-mark-up provisions when the physician or supplier who *orders* the test (or his group) seeks to bill for *either* the professional and/or the technical component of the test. The rule does not apply if the performing or supervising physician “shares a practice” with the billing supplier. There are two tests to determine whether the physicians “share a practice:” the “substantially all” test and the “site of service” test. Under the site of service test, the anti-markup rule does not apply if the performing physician is an owner, employee or independent contractor of the billing supplier *and* the applicable components of the test are performed in the office of the billing supplier. The office of the billing supplier is any space in the “same building” in which the ordering physician/supplier regularly furnishes care. The term “same building” has the same meaning as in the Stark regulations. However, a test performed in a Stark “centralized building” would likely not satisfy the site of service test.
- Legal Issue:* Therefore, where physician organizations have structured themselves to meet the Stark centralized building criteria, this final rule may require physicians/groups

to restructure in order to avoid application of the anti-markup rule.

- (b) Payment amount: Under the final rule, Medicare will pay the lower of:
 - (i) the performing supplier's net charge to the billing physician/group
 - (ii) the billing physician's actual charge or
 - (iii) the Medicare physician fee schedule amount for the test if the performing supplier had billed it directly.

- f. E-Prescribing Incentive: Effective 1/1/09, Medicare will make an incentive payment to physicians who meet certain thresholds in using e-prescribing. *See* MPFS Final Rule for FY 2009, 73 Fed. Reg. 69726 (11/19/08).

3. Commercial/Managed Care

- a. Contract with Participating Provider
 - i. Contract terms govern reimbursement
- b. Non-Participating Provider (No contract)
 - i. Bill charges to patients

4. Reassignment Rules: Who can the Payor Pay?

- a. Legal Authority:
 - i. Medicare reassignment provisions governing physicians and suppliers under Part B: 42 U.S.C. § 1395u(b)(6); SSA § 1842(b)(6); 42 C.F.R. § 424.80.
 - ii. Medicaid: Social Security Act § 1902(a)(32), 42 U.S.C. § 1902(a); 42 C.F.R. § 447.10; NY Social Services Law § 367-a(1)(a); 18 N.Y.C.R.R. § 360-7.5(a)(2)(ii).
- b. Rule: Medicare and Medicaid both require that payment be made directly to the physician and prohibit reassignment of the physician's right to receive payment, unless the payment arrangement fits within an exception set forth in statute or regulation. These rules were designed to protect against abuses described as "factoring." The exceptions include allowing reassignment to the:
 - i. Employer
 - ii. Hospital in which the physician is working
 - iii. Contracting party – but only if the contract requires the physician to reassign the right to bill.

V. AMBULATORY SURGERY CENTER (“ASC”)

A. Structure

1. NY: Structure as a DTC, if freestanding ASC. (Hospital-based ASCs are reimbursed differently from freestanding ASCs, and are not covered under this section).
2. Federal: Must meet Medicare conditions of participation as an ASC. 42 C.F.R. §§ 416.2, 416.40 - 416.49.

B. Reimbursement

1. Medicaid
 - a. *Before 3/1/09*: 10 N.Y.C.R.R. Part 86-4, § 86-4.40.
 - b. *After 3/1/09*: 10 N.Y.C.R.R. Part 86-8 (APGs), with different base rate from hospital outpatient clinics, hospital-based ASCs, and DTCs. Physician costs are excluded from the rate and must be billed separately under the Medicaid physician fee schedule.
2. Medicare: SSA § 1833(i); 42 C.F.R. Part 416
 - a. Facility fee is paid to ASC for facility costs and services, and excludes the cost of physician services.
 - b. Professional fee is paid directly to physicians for professional services.
 - c. *Before 1/1/08*: 42 C.F.R. § 416.121 *et. seq.*
 - d. *Effective 1/1/08*: Major changes due to Section 626 of the Medicare Modernization Act of 2003 (P.L. 108-173).

VI. FEDERALLY QUALIFIED HEALTH CENTER (“FQHC”) and RURAL HEALTH CENTER (“RHC”)

A. Structure

1. NY: Structure as a DTC.
2. Federal: Must meet Medicare conditions of participation to be an FQHC or FQHC look-alike 42 U.S.C. § 1396a(aa); 42 C.F.R. §§ 405.2430 *et seq.* (or an RHC - 42 C.F.R. Part 491). These require an independent board of directors with a significant percentage of directors who are community members that use the facility. Cannot be owned by a hospital. These also require that the FQHC be located in an underserved area.

B. Reimbursement

1. Medicaid FFS (Public Health Law § 2807(8)):
 - a. *Before 3/1/09*: All FQHCs: Cost-based rate with operating and capital components. Operating costs are based on costs in effect on 9/30 of the prior period, increased by the Medicare Economic Index, subject to a cap based on the average operating component for like facilities in the same geographic area. Capital costs are a pass through of rate year actual costs.
 - b. *After 3/1/09*: An FQHC can elect to be reimbursed using APGs. Any FQHC electing APG reimbursement cannot be reimbursed less than its rate would be under the FQHC methodology. Public Health Law § 2807(8)(f).
2. Medicare: 42 C.F.R. § 405.2460 et seq.
3. Medicaid Managed Care: FQHC receives a “wrap around” payment equal to the difference between the rate it negotiates with a managed care organization (“MCO”) that has a Medicaid managed care contract and the Medicaid FFS rate. Section 4712 of the Balanced Budget Act of 1997, amending 42 U.S.C. § 1396a(a)(13)(C) and 42 U.S.C. § 1396b(m)(2)(A).

VII. INDEPENDENT DIAGNOSTIC TREATMENT FACILITY (“IDTF”)

A. Structure

1. NY: Can be structured as a DTC, PLLC, or an unlicensed business entity (such as a business corporation or limited liability company).
2. Medicare: Must meet conditions of participation for an IDTF. 42 C.F.R. § 410.33; CMS Program Memo B-00-44 (8/30/00).

B. Reimbursement

1. Medicaid
 - a. If structure as a DTC, DTC reimbursement rules apply.
 - b. If structure as a PLLC, physician reimbursement rules apply.
 - c. If structure as an unlicensed business entity, the entity *cannot* bill Medicaid directly for the technical component. See 18 N.Y.C.R.R. §§ 505.17 and 533.6.

2. Medicare
 - a. Technical Component: Reimbursed under the Medicare Physician Fee Schedule.
 - b. Professional Component: *If* allowed by NY law to perform the professional component or to “purchase” it under a reassignment (i.e. if structured as a PLLC or a DTC), can bill the professional component under the Medicare Physician Fee Schedule, subject to the provisions of the Anti-Mark-up rule discussed above.

VIII. PORTABLE X-RAY SUPPLIER

A. Structure

1. NY: *See* discussion under IDTF, above. Note - formerly a DTC could only be licensed to operate a fixed site. Recently, DOH has licensed DTCs to operate certain mobile testing facilities.
2. Medicare: Meet conditions of participation for a portable x-ray supplier. 42 C.F.R. § 486.100-110; Medicare Benefit Policy Manual, Ch. 15, ¶ 80.4.

B. Reimbursement

1. Medicaid. *See* discussion under IDTF, above.
2. Medicare
 - a. Technical Component: Reimbursed under the Medicare Physician Fee Schedule.
 - b. Professional Component: *See* discussion under IDTF.
 - c. Set up fee: A portable x-ray supplier can bill a set up fee (which an IDTF cannot). Medicare Claims Processing Manual § 90.4.
 - d. Transportation fee: A portable x-ray supplier can bill a transportation fee (which an IDTF cannot). Medicare Claims Processing Manual § 90.3