TrailBlazer Health Enterprises, LLC
Guide to Preparation of Attestation

SAMPLE PROVIDER-BASED ATTESTATION STATEMENT FORMAT

(Section I - Required General Information)

Main provider's Medicare provider number: ________________

Main provider's name: ____

Main provider's physical address:____
(include city and county) ____

Contact name and phone number: ____

Facility's name (requesting provider-based status) ____________________________________

Facility's exact physical address: ____

Facility's Medicare provider number (if different) __________________________

Exact distance between main provider and facility (in yards or miles) __________________

County that the facility is located ____

Date when main provider established or assumed ownership of the facility ____/ ____/ ____

Please check one of the following that best describes the facility:
____ Department of the hospital
____ Remote location of the hospital
____ Satellite facility
____ Other - please specify: ____
(RHC, FQHC, Physician's Office, etc.)

	Yes	No
Is the facility part of a multi-campus hospital?	☐	☐
Is the facility operated under Management Contracts? (If YES, also complete Section IV-5)	☐	☐
Is the facility operated as a Joint Venture? (If YES, also complete Section III-6)	☐	☐
Has a Change of Ownership occurred and currently under CMS review?	☐	☐
Has the facility received CMS approval for enrollment as a Practice Location of the Main Provider?	☐	☐

(If NO, See Section 4A-4H of Form CMS 855A or contact TrailBlazer Provider Enrollment (866)-528-1603.)

Types of services performed by the facility:

____

____

Section II - ON-CAMPUS OR OFF-CAMPUS DETERMINATION

Please check one that identifies the Location of the facility to the main provider:

______ Inside the main provider's primary building.
______ In the physical area immediately adjacent to the main provider's primary building.
______ Other areas or structures that are not strictly contiguous to the main provider's primary building, but are located within 250 yards of the main provider's primary building.

Documentation: A detailed map to verify the *exact* distance between main provider and facility, i.e., a plat of the complex or a map from the Internet Web site, MapQuest.

Check the appropriate box based on the results above:

______ *ON-CAMPUS*: If any of the blanks above are checked and the facility requesting provider-based status is within 250 yards of the main provider, the facility is considered to be located On-Campus. *Section III* must be completed.

______ *OFF-CAMPUS*: If none of the blanks above are checked and the facility requesting provider-based status is within 35 miles of the main provider, then the facility is considered to be located Off-Campus. *Sections III & IV* must be completed.

If the facility is located more than 35 miles from the main provider, check here _______ and see Section IV.3(b) for exceptions that might apply.

I certify that I have read 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 CFR §413.65(a)(2) and is in compliance with the following provider-based requirements 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 CFR §413.65(a)(2) and is in compliance with the following provider-based requirements 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. 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 TrailBlazer Health Enterprises, LLC and a copy to CMS, the documentation showing the basis for these attestations (for each regulatory requirement).*

Section III – REQUIRED FOR BOTH ON-CAMPUS AND OFF-CAMPUS FACILITIES)

The criteria for provider-based status at 42 CFR § 413.65 (d) applicable to ALL facilities are listed below. It is a requirement that documentation for the basis of each be maintained, and to make that documentation available to CMS or the FI upon request. For off-campus facilities, documentation must also be submitted with the Attestation. Please check the appropriate box to indicate that the requirements are met.

	Yes	No
1. Licensure: The facility is operated under the same license as the main provider (where permitted by law).	☐	☐

* Exceptions: ____

Documentation Examples: A copy of the facility's business license and JACHO accreditation, if applicable. If the state where the facility and main provider are located require separate licenses, provide support.

2. Clinical Services:	Yes	No
a. Professional staff of the facility have clinical privileges at the main provider.	☐	☐
b. The main provider maintains the same monitoring and oversights of the facility as it does for any other department of the hospital.	☐	☐
c. The medical director of the facility maintains a reporting relationship with a chief medical officer of the main provider with the same type of supervision and accountability as any other director of the main provider.	☐	☐
d. Medical staff committees or other professional committees at the main provider are responsible for the medical activities in the facility.	☐	☐
e. Medical records for patients in the facility are integrated into a unified retrieval system of the main provider.	☐	☐
f. Inpatient/outpatient services of the facility and the main provider are integrated, and patients treated at the facility that require care have full access to the services of the main provider.	☐	☐

Comments: ____

Documentation Examples: A copy of the main provider's organizational chart, list of personnel working at the facility with titles and name of employer, other information showing the responsibility and relationship between the facility and the main provider.

	Yes	No
3. Financial Integration: Financial operations are fully integrated within the financial systems of the main provider, as evidenced by shared income and expenses between the main provider and the facility.	☐	☐

Comments: ____

Documentation: A copy of the appropriate section of the main provider's chart of accounts or trial balance that shows the location of the revenues and expenses.

(Section III – REQUIRED FOR BOTH ON-CAMPUS AND OFF-CAMPUS FACILITIES)

	Yes	No
4. Public Awareness: The facility is held out to the public as a part of the main provider. When a patient enters the facility, they are aware that they are entering the main provider and are billed according.	☐	☐

Comments: ____

Documentation Examples: Copies of patient registration forms, letterhead, Web sites, advertisements, signage that shows that the facility is clearly identified with the main provider.

5. Obligations of Hospital Outpatient Departments & Hospital-Based Entities: Please check the appropriate box to indicate that the obligations are met.

	Yes	No
a. Patient Anti-Dumping Rules – Facility complies with criteria listed in 42 CFR § 489.2.	☐	☐
b. Site-of-Service – Physicians providing services in the facility use the correct site-of-service-code on CMS-1500 claim form.	☐	☐
c. Provider Agreement – Facility complies with terms of Medicare provider agreement.	☐	☐
d. Non-Discrimination Provisions – Physicians working in the facility comply with the non-discrimination provisions of 42 CFR § 489.10 (b).	☐	☐
e. Consistent Treatment as Outpatient - Facility treats all Medicare patients as hospital outpatients for billing purposes.	☐	☐
f. 72 Hour Payment Window – Facility complies with all applicable Medicare payment window provisions. (Does not apply to CAHs.)	☐	☐
g. Health and Safety Rules – Facility meets all applicable health and safety rules for Medicare-participating hospitals.	☐	☐

Comments: ____

Documentation Examples: A copy of EMTALA policy is in place at the facility.

6. Provider-based Status for Joint Venture:
If does not apply (N/A), indicate here: _______

The facility or organization operated as a joint venture is:

	Yes	No
a. Partially owned by at least one provider.	☐	☐
b. Located on the main campus of the main provider who is a partial owner.	☐	☐
c. Provider-based to the main provider on whose campus the facility is located.	☐	☐
d. Meets all the requirements applicable to all provider-based facilities in § 413.65 (d).	☐	☐

(Section III – REQUIRED FOR BOTH ON-CAMPUS AND OFF-CAMPUS FACILITIES)

IF CONSIDERED ON-CAMPUS, and * any response in Section III is "*NO*", the facility does not qualify for provider-based status. If all responses are "*YES*", then go to Section V - Provider Attestation. A map showing distance between the facility and the main provider should accompany Attestation.

If CONSIDERED OFF-CAMPUS, and * any response in Section III is "NO", the entity does not qualify for provider-based status. If all responses are "YES", then go to Section VI – Additional OFF-CAMPUS Requirements. Submit documentation with Attestation that supports all required criteria.

**Licensure Exceptions will be noted.*

(Section IV – ADDITIONAL OFF-CAMPUS REQUIREMENTS)

1. Ownership and Control:
   Please check the appropriate box to indicate that the requirements are met.

	Yes	No
a. The facility is 100 percent owned by the main provider.	☐	☐
b. The facility is operated under the same governing body.	☐	☐
c. The facility is operated under the same organizational documents as the main provider.	☐	☐
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 and final approval for medical staff appointments in the facility.	☐	☐

Comments: ____

Documentation Examples: Copies of Articles of Incorporation and the Bylaws for both the main provider and the facility.

(Section IV – ADDITIONAL OFF-CAMPUS REQUIREMENTS)

	Yes	No
2. Administration and Supervision:		
a. The facility is under direct supervision of the main provider.	☐	☐

Documentation Example: A list of key administrative staff (position/titles only) at the main provider and facility that reflect a reporting relationship.

	Yes	No
b. The facility is operated under the same monitoring and oversight by the main provider as any other department of the main provider, and is operated just as any other department with regard to supervision and accountability.	☐	☐
(i) Facility director maintains a reporting relationship with a manager of the main provider.	☐	☐

Documentation Example: A copy of the facility's organizational chart.

	Yes	No
(ii) Facility director is accountable to the governing body of the main provider.	☐	☐

Documentation Example: A written description of the of the day-to-day reporting requirements and accountability procedures of the facility's director.

	Yes	No
c. The following administrative functions of the facility are integrated with those of the main provider:		
1) Billing Services.	☐	☐
2) Records.	☐	☐
3) Human Resources.	☐	☐
4) Payroll.	☐	☐
5) Employee Benefit Package.	☐	☐
6) Salary Structure.	☐	☐
7) Purchasing Services:	☐	☐
(i) Contracted out under the same contract agreement.	☐	☐
(ii) Handled under different contract agreements, with the contract of the facility being managed by the main provider.	☐	☐

Comments: ____

Documentation Example: A list of the various administrative functions (e.g.,laundry, payroll, billing services) at the facility that are integrated with the main provider. Contracts for administrative functions that are completed under arrangements for the main provider and the facility.

(Section IV – ADDITIONAL OFF-CAMPUS REQUIREMENTS)

	Yes	No
3. Location:		
a. The facility is located within 35 miles of the main provider.	☐	☐
Note: A Rural Health Clinic (RHC) that is otherwise qualified as a provider-based facility of a hospital that is located in a rural area and has fewer than 50 beds is not subject to this criteria.		
b. If the facility is NOT located within 35 miles of the main provider, check one of the following exceptions that applies:		
(1) The facility is owned and operated by a provider that has a disproportionate share adjustment greater than 11.75 percent and is:		
(a) Owned or operated by a unit of state or local government;	☐	☐
(b) A public or nonprofit corporation that is formally granted governmental powers by a unit of state or local government; OR	☐	☐
(c) A private hospital that has a contract with a state or local government that includes the operations of clinics located off the main campus of the hospital.	☐	☐
(2) The facility 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 is filed with CMS, and for each subsequent 12-month period:		
(a) At least 75 percent of the patients served by the facility reside in the same ZIP code areas as 75 percent of the patients served by main provider;	☐	☐
(b) At least 75 percent of the patients served by the facility who require the type of care furnished by the Main Provider received that care from that Provider; OR	☐	☐
(c) The facility is unable to meet the criteria because it was not in operation during all of 12-month period previously described, the facility is located in a zip code area included among those that, during all of the 12-month period accounted for at least 75 percent of the patient population served by the main provider.	☐	☐

Documentation: Records showing that during the 12-month period immediately preceding the first day of the month in which the Attestation is filed with CMS, and records for each subsequent 12-month period that meet the above criteria.

	Yes	No
(3) The facility is not located in the same state as the main provider, but the fFacility is consistent with the laws of that state. (Supporting documentation must be provided.)	☐	☐

(Section IV – ADDITIONAL OFF-CAMPUS REQUIREMENTS)

4. Obligations of Hospital Outpatient Departments & Hospital-Based Entities:

When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based facility (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 must provide written notice to the beneficiary of the amount of the beneficiary's potential financial liability, before the delivery of services. The notice meets the following guidelines:

	Yes	No
(a) Beneficiary can read and understand the notice.	☐	☐
(b) If the exact type and extent of care needed is not known, the hospital will furnish a written notice to the patient that explains that the beneficiary will incur a coinsurance liability to the hospital that would not be incurred if the facility were not provider-based.	☐	☐
(c) The notice will state that the patient's actual liability will vary if the amount is estimated.	☐	☐
(d) The notice will be presented to the beneficiary's authorized representative before delivery of services if the beneficiary is unconscious or under duress.	☐	☐
(e) When examination and treatment is required to be provided by the antidumping rules, notice must be given as soon as possible after the existence of an emergency is ruled out or the emergency condition has been stabilized.	☐	☐

5. Management Contracts:

	Yes	No
(a) The entity is operated under a management contract.	☐	☐
(i) The main provider employs the staff of the facility, except those that are paid under a fee schedule.	☐	☐
(ii) The administrative functions of the facility are integrated with those of the main provider.	☐	☐
(iii) The main provider has significant control over the operations of the facility.	☐	☐
(iv) The management contract is held by the main provider.	☐	☐

Documentation: A copy of the management contract.

Comments: ______________________________

SECTION V – PROVIDER ATTESTATION

* 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 a 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 makes or uses any false writing or document knowing the same to contain any 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).