



Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations

MLN Matters Number: SE18023

Related Change Request (CR) Number: 9613; 9907

Article Release Date: October 12, 2018

Effective Date: N/A

Related CR Transmittal Numbers:
R1704OTN and R1783OTN

Implementation Date: N/A

PROVIDER TYPES AFFECTED

This MLN Matters® Special Edition Article is intended for Outpatient Prospective Payment System (OPPS) providers that have multiple service locations submitting claims to Medicare A/B Medicare Administrative Contractors (MACs).

WHAT YOU NEED TO KNOW

This article conveys the activation of systematic validation edits for the enforcement of requirements in the Medicare Claims Processing Manual, Chapter 1, and Section 170 which describes Payment Bases for Institutional Claims. These requirements are not new requirements. Previously, these requirements were discussed in CRs 9613 and 9907, both of which were effective on January 1, 2017. MLN Matters articles for CRs 9613 and 9907 are available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9613.pdf> and <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf>, respectively. Make sure your billing staff is aware of these instructions.

BACKGROUND

Increasingly, hospitals operate an off-campus, outpatient, provider-based department of a hospital. In some cases, these additional locations are in a different payment locality than the main provider. In order for Medicare Physician Fee Schedule (MPFS) and OPPS payments to be accurate, the service facility address of the off-campus, outpatient, provider-based department of a hospital facility is used to determine the locality in these cases.

Additionally, in accordance with Section 1833(t)(21) of the Social Security Act (the Act), as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), non-exceptioned services provided at an off-campus, outpatient, provider-based department of a hospital were

required to be identified; as the payment rate for non-excepted items and services billed on an institutional claim are to be paid under the MPFS and not the OPPS rates.

Claim level information:

Medicare outpatient service providers report the service facility location for an off-campus, outpatient, provider-based department of a hospital in the 2310E loop of the 837 institutional claim transaction. Direct Data Entry (DDE) submitters also are required to report the service facility location for an off-campus, outpatient, provider-based department of a hospital. Paper submitters report the service facility address information in Form Locator (FL) "01" on the paper claim form. For MPFS services, Medicare systems use this service facility information to determine the applicable payment method or locality whenever it is present.

Additionally, Medicare systems will validate service facility location to ensure services are being provided in a Medicare enrolled location. The validation will be exact matching based on the information submitted on the Form CMS-855A submitted by the provider and entered into the Provider Enrollment, Chain and Ownership System (PECOS). Providers need to ensure that the claims data matches their provider enrollment information.

When all the services rendered on the claim are from the billing provider address, providers are:

- To report the billing provider address only in the billing provider loop 2010AA and not to report any service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).

When all the services rendered on the claim are from one campus of a multi-campus provider that report a billing provider address, providers are:

- To report the campus address where the services were rendered in the service facility location in loop 2310E if the service facility address is different from the billing provider address loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital, providers are:

- To report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop 2310E (or in DDE MAP 171F screen for DDE submitters).

When there are services rendered on the claim from multiple locations:

- If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).
- If no services on the claim were rendered at the billing provider address, providers should report the service facility address in loop 2310E (or in DDE MAP 171F screen for DDE submitters) from the first registered encounter of the "From" date on the claim.

NM1 - SERVICE FACILITY LOCATION NAME – 60 Characters 837I – 25, UB-04

N3 - SERVICE FACILITY LOCATION ADDRESS

N301 – 55 Characters 837I – 25 Characters on the UB-04

N302 – 55 Characters 837I – not on UB-04 paper form

N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE

N401 City Name – 30 Characters 837I – 12 Characters on the UB-04

N402 State Code – 2 Characters 837I – 2 Characters on the UB-04

N403 Postal Code – 15 Characters 837I – 9 Characters on the UB-04

DDE Screen MAP 171F:

MAP171F PAGE /.../...

..... SC .. INST CLAIM :...:...

HIC TOB ... S.../LOC....

PROVIDER PRACTICE LOCATION ADDRESS

ADDRESS 1:

ADDRESS 2:

CITY : STATE: ... ZIP:.....

.....

.....

Line level information:

In the CY 2015 OPPS Final Rule (79 FR 66910-66914), the Centers for Medicare & Medicaid Services (CMS) created a HCPCS modifier for hospital claims that is to be reported with each claim line with a HCPCS for outpatient hospital items and services furnished in an off-campus provider-based department (PBD) of a hospital. This 2-digit modifier was added to the HCPCS annual file as of January 1, 2015, with the label “PO.” Reporting of this new modifier was voluntary for CY 2015, with reporting required beginning on January 1, 2016.

In accordance with Section 1833(t)(21) of the Act, as added by section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS established a new modifier “PN” (Non-exception service provided at an off-campus, outpatient, provider-based department of a hospital) to

identify and pay non-excepted items and services billed on an institutional claim. Effective January 1, 2017, non-excepted off-campus provider-based departments of a hospital are required to report this modifier on each claim line with a HCPCS for non-excepted items and services. The use of modifier "PN" will trigger a payment rate under the MPFS. CMS expects the PN modifier to be reported with each non-excepted line item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services; with reporting required beginning on January 1, 2017.

As a result, effective January 1, 2017, excepted off-campus provider-based departments of a hospital must continue to report existing modifier "PO" (Services, procedures and/or surgeries provided at off-campus provider-based outpatient departments) for all excepted items for services reported with a HCPCS furnished.

National Testing

Round 1 Testing

During the week of July 23 through July 30, 2018, CMS performed a national trial activation of the Fiscal Intermediary Shared System (FISS) Edits 34977 and 34978 in production environments. Reason Codes 34977 (claim service facility address doesn't match provider practice file address) and 34978 (Off-campus provider claim line that contains a HCPCS must have a PN or PO) were activated. The testing was transparent to providers as most claims impacted by the test were suspended for one (1) billing cycle and then editing was turned off so the claim could continue processing as normal.

This national test brought to light that many providers are not sending the correct exact service facility location on the claim that produces an exact match with the Medicare enrolled location as based on the information entered into the PECOS for their off-campus provider departments.

Most discrepancies had to do with spelling variations. For example, in PECOS the word entered was "Road" as part of their address, but the provider entered "Rd" or "Rd." as part of their address on the claim submission. Another example, in PECOS the word entered was "STE" as part of their address, but the provider entered "Suite" as part of their address on the claim submission.

Round 2 Testing

Providers should also ensure that all practice locations are present in PECOS and if any locations are not in PECOS to submit the 855A to add the location(s). Providers can review their practice locations in PECOS and/or the confirmation letter from PECOS when they last enrolled that was received from their A/B MAC to ensure that their service facility address for their off-campus provider department locations provided on claims is an exact match.

CMS will conduct an additional national testing in November 2018. Providers should use the time before this national testing to correct the off-campus provider department location addresses within their billing systems to match exactly PECOS for their off-campus provider departments.

Full Production

After the November national test in November 2018 has been completed, CMS will review the results. One suggestion given during our Round 1 Testing was to have the practice location addresses available in DDE so providers could query their own PECOS practice location addresses. This should greatly reduce uncertainty as to the exact information found in the PECOS file and make claim practice location address comparison more efficient. As a result CMS has issued instructions to the FISS maintainer to make the practice location address screen available to providers in DDE at the April 2019 system quarterly release. Starting in April 2019, the practice location screen will be available in DDE. Full production implementation has been postponed until such time. CMS will continue with additional round(s) of testing to ensure that we have a smooth implementation of the edits.

Once the April 2019 Quarterly release has been implemented, CMS will direct A/B MACs to permanently turn on the edits and set them up to Return-to-Provider (RTP) claims that do not exactly match. Providers can make corrections to their service facility address for a claim submitted in the DDE MAP 171F screen for DDE submitters. **Providers who need to add a new or correct an existing Practice location address will still need to submit a new 855A enrollment application in PECOS.**

CMS expects that the 2 year time frame that the edits have not been active have provided ample time for providers to validate their claims submission system and the PECOS information for their off-campus provider departments are exact matches.

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
October 12, 2018	Initial article released.

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2017 American Medical Association. All rights reserved.

Copyright © 2018, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of

the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.