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Update Your Hospital's CMS-855A with Off-Campus Services Locations Before October 2019: Medicare is Preparing to Enforce New Claim Requirements

If your hospital is enrolled as a multi-campus hospital or has off-campus, outpatient, provider-based facilities, you should be aware that Medicare has completed three (3) rounds of testing and is preparing to turn on billing edits to ensure hospitals are properly reporting the service facility location on hospital UB claims. Medicare will cross-reference the address indicated on the claim for an EXACT match with the facility locations on file in the Provider Enrollment, Chain and Ownership System (PECOS) in order to ensure that services are being performed at an enrolled Medicare location. The CMS also requires that either modifier PO or PN be present on all service lines with Healthcare Common Procedure Coding System (HCPCS) codes when the service is provided by an off-campus provider-based department of the hospital.

In **MLN Matters SE18002,** Medicare introduced the requirement that hospitals must report the service facility location for multi-campus facilities and off-campus, outpatient, provider-based departments on claims effective January 1, 2017. If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the 2010AA loop of the 837 institutional claim transaction and do not report the service facility location in loop 2310E. When all services on a claim are rendered at a multi-campus provider location that is not the billing facility address or an off-campus, outpatient, provider-based department of the hospital, the service facility address must be reported. If services are provided at multiple off-campus, provider-based departments on the same date, the service address from the first registered encounter of the "From" date is reported on the claim.

On October 12, 2018, the CMS released **MLN Matters SE18023** regarding the Activation of Systematic Validation Edits for Outpatient Prospective Payment System (OPPS). This notice informed providers of Round 1 testing results that found many providers are still not reporting the correct service location and that most discrepancies had to do with spelling variations. For example, in the PECOS the word entered was "Road" as part of the address but "Rd" was submitted on the claim. The CMS also instructed the Fiscal Intermediary Shared System (FISS) maintainer to make practice location address screens available to providers in Direct Data Entry (DDE) so providers can query their own PECOS practice location addresses. A second round of testing was scheduled for November 2018, with full implementation of the program scheduled for April 2019.

On June 28, 2019, the CMS revised **MLN Matters SE19007** to provide an update on Round 3 testing and to announce a delay of full implementation until October 2019. The CMS reports the edit data are still under review, but at this point no major issues are identified. The CMS expects that the 2½ year timeframe 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-based departments are exact matches. This means it is critical for impacted hospitals to assess readiness in the following areas:

- CMS-855A Enrollments: Ensure your hospital's CMS-855A enrollment is up-to-date and all multi-campus and off-campus provider-based facilities are listed in the PECOS. It can take 45-120 days to process a change request on a CMS-855A enrollment, so it is important to file all necessary changes or updates with the CMS as soon as possible.

- IT System Capabilities: Ensure your hospital billing system is set up to include service facility locations in the 2310E loop of the 837 institutional claim transaction.

- Modifiers PO or PN: "Excepted" off-campus provider-based departments report modifier PO on all services and "non-excepted" off-campus provider-based departments report modifier PN.

Failure to meet these requirements could result in unclean claims, payment delays, and/or under/over-payments for services rendered at off-campus, outpatient, provider-based facilities.

Please contact us for assistance on CMS-855A enrollments, provider-based facilities, or general questions on these Medicare regulations.

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