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Ensuring correct billing and coding for provider-based departments

by Melody W. Mulaik, MSHS, CRA, RCC, RCC-IR, CPC, COC, FAHRA, and Briauna Driggers

Now that the guidelines for off-campus provider-based departments (PBDs) have been in place for a few years, it might be tempting for organizations to overlook the need for ongoing internal audits of current PBDs and appropriate strategic planning for future ones. Ensuring the foundational processes in place are correct when considering opening new locations will go a long way in achieving success due to myriad operational requirements.

PBDs can be on- or off-campus of the hospital; however, off-campus departments are designated as excepted or nonexcepted and come with a few extra regulatory guidelines and hoops to jump through.

Section 603 of the Bipartisan Budget Act of 2015 established a site-neutral payment policy for provider-based, off-campus hospital outpatient departments (HOPD) effective November 2, 2015.[1] Specifically, it defines an off-campus outpatient department as one located more than 250 yards from the hospital's main buildings. This section of the bill addressed the concern that hospitals were acquiring physician practices at an alarming rate and establishing them as outpatient departments of the hospital. Typically, HOPD rates—when added to the physician rate for the same services—are paid more than those provided in ambulatory surgery centers (ASC), physicians' offices, and/or community outpatient facilities when factoring in the global or combined totals.

To appropriately value the services provided in PBDs, the Centers for Medicare & Medicaid Services (CMS) had to determine how to value the services provided in the PBD. CMS believed a value close to that of the nonfacility rate for the same service in the office setting would be most appropriate and considered requiring PBDs to bill for services on a CMS 1500 claim form—the same ones used by physicians and office settings. Because hospitals (facility settings) are not equipped to bill on CMS 1500, they bill on UB 04; CMS instead applied different logic.

PBDs, from a regulatory aspect, are considered facility settings, billed on UB 04 claim forms, and follow the same rules for physician supervision, packaging, and bundling as hospital outpatient departments do; however, from a payment perspective, they are reimbursed under the Medicare Physician Fee Schedule (MPFS). CMS established a Physician Fee Schedule (PFS) Relativity Adjuster, a factor that reduces the corresponding Outpatient Prospective Payment System (OPPS) payment amount for the same service by a set percentage to determine the payment amount in the PBD. The initial PFS Relativity Adjuster was set at 50% of the OPPS Ambulatory Payment Classification (APC) payment rate; this was adjusted one year later to 40% and has remained since 2018. Any service performed in the off-campus PBD is paid 40% of the OPPS rate—a 60% reduction from the established rate. Physicians who bill for their services or the professional components separately are paid at the facility rate

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under MPFS as they would in a hospital outpatient department.

An excepted off-campus PBD is one which was established and billing CMS for services provided within the previous 35-mile radius prior to November 2, 2015. These locations are still considered outpatient departments of the hospital and are paid at the full OPPS rate—except for the clinic visit code G0463 which is paid at the PFS Relativity Adjuster rate for all PBDs. Excepted PBDs must report modifier "PO" (*Excepted service provided at an off-campus, outpatient, provider-based department of a hospita*l) on every procedure or service billed to identify their establishment and history as an outpatient department of the hospital. Section 603 does not include satellite hospital facilities or hospital-owned, provider-based entities such as home health agencies or skilled nursing facilities. It is important to note that excepted off-campus PBDs will lose their exemption if they relocate or change ownership—except for emergency-approved circumstances.

A nonexcepted off-campus PBD is a department that did not provide any services or items to patients prior to November 2, 2015. For those which were new and open at this point or in midconstruction, an exception had to be filed with CMS to be granted excepted status, but all other entities after this date are considered nonexcepted. Nonexcepted off-campus PBDs must report modifier "PN" (*Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital*) to every procedure or service billed to identify their status and ensure the correct payment amount with the PFS Relativity Adjuster of 40% of the associated OPPS APC. Failure to report modifier PN on the nonexcepted PBD claims would result in overpayment of services as it would appear the location was an outpatient department of the hospital paid at the full rate.

MLN Matters® MM9907 addresses the appropriate identification of all off-campus PBDs. "If a hospital claim is submitted with a service facility location that was not included on the CMS 855A enrollment form, the claim will be Returned to the Provider (RTP) until the CMS 855A enrollment form and claims processing system are updated."[2]

Regardless of whether a PBD is excepted or nonexcepted, physicians must report place of service (POS) code 19 (*Off Campus-Outpatient Hospital*) on their claims. The physician is still paid at the MPFS facility rate, as they would when reporting POS 22 (*On Campus-Outpatient Hospital*).

Regulatory guidelines for on- and off-campus

There are a few specific regulatory criteria on- or off-campus (excepted/nonexcepted) PBDs must follow. For example, physicians must operate under the same license as the main provider unless the state requires a separate license.

There are other requirements related to clinical services, finance, legal, and more. Specifically:

Clinical services

PBDs are under the direction of the hospital that owns them. The physicians and other qualified healthcare professionals must have privileges associated with the hospital. Additionally, the hospital must also ensure the same monitoring and oversight at the off-campus locations as it does for the main campus. There must be an integrated medical record with the hospital as well as integration of inpatient and outpatient services.

Financial and public integration criteria

PBDs must be fully integrated into the hospital and included in the hospital's cost report(s) to Medicare. They must also be presented to the public and payers as part of the hospital.

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Obligations

PBDs are bound to the same legal and contractual requirements the hospital must adhere to, including but not limited to:

- Anti-dumping rules
- All terms of the hospital's provider agreement
- Physician anti-discrimination provisions
- Physician supervision guidelines
- Treatment of Medicare patients in accordance with regulations
- Same pre-admission bundling provisions
- All applicable health and safety rules

Address requirements for off-campus

The PBD must exactly match the location listed in the Provider Enrollment Chain and Ownership System and must contain modifier PO or PN on each applicable billed service.

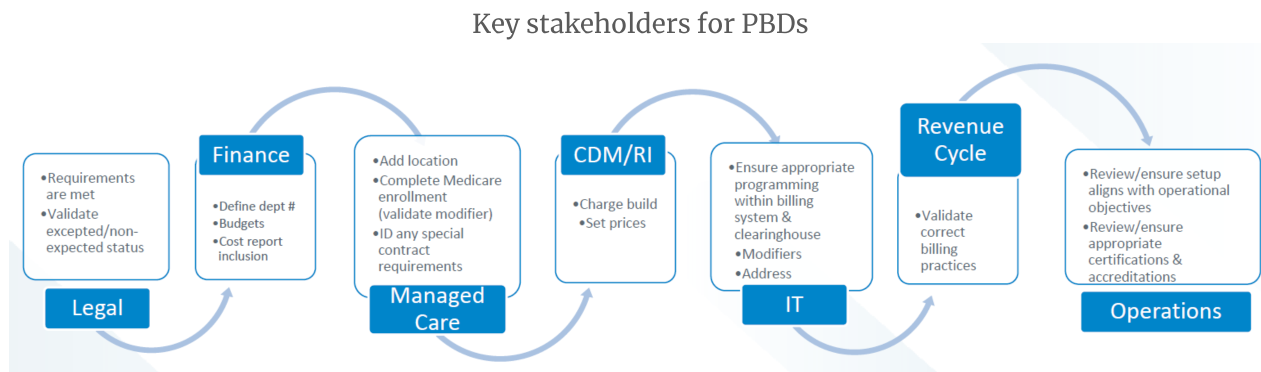
Physician supervision

Per the 2018 MPFS final rule, "The supervision rules that apply for hospitals continue to apply for nonexcepted off-campus PBDs that furnish nonexcepted items and services. The amendments made by section 603 of the Bipartisan Budget Act of 2015 did not change the status of these PBDs, only the status of, and payment mechanism for, the services they furnish."[3] Diagnostic procedures follow the requirements in MPFS for individual tests. At a minimum, therapeutic services require general supervision of services but may adjust to the direct or personal decision of the hospital and physician.

Key steps to ensuring correct set-up and ongoing compliance

It is critical to complete an appropriate multidisciplinary review before set-up using the Provider-Based Reference Guide "playbook."[4] It is imperative to review everything from legal and financial requirements to revenue cycle and operational practices.

Key stakeholders for PBDs



As new locations are established, there are several key questions to consider:

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- Who should requests be submitted to?
- How far in advance of the proposed scheduled opening date should they be submitted? *Hint: a minimum of six months is a good benchmark.*
- Who has ultimate responsibility for the completion and submission of the request form? This will depend on your organizational structure. Is your hospital president or their designee overseeing the new facility?

These are just a few things to consider before setting up a PBD, in addition to the regulatory and compliance requirements that must be monitored due to frequent changes.

Compliance is a definite key to success, and some may not realize just how vital it is. A PBD (or any healthcare facility) must be ready to perform ongoing audits and troubleshoot issues as they arise. Site visits and refunds may also be necessary until all appropriate procedures are in place.

Summary

It is essential to keep current on both state and federal regulatory guidelines. This will ensure accurate billing and coding for compliance and appropriate reimbursement. You must also have a clear approval process in place with up-to-date tools and accountability for new facilities.

Be prepared to monitor ongoing compliance to ensure good recordkeeping for continued efforts. Ultimately, documentation will be your best bet in keeping your house in order.

Takeaways

- Understand Section 603 of the Bipartisan Budget Act of 2015.
- Go over the exemptions outlined for off-campus provider-based departments (PBDs).
- Learn the difference between on- and off-campus regulatory guidelines.
- Review the significant steps to ensuring off-campus PBDs are set up correctly.
- Understand the key steps to ongoing compliance within an off-campus PBD.

1 Bipartisan Budget Act of 2015, Pub. L. No. 114-74, H.R. 1314, 114th Congress, https://www.govinfo.gov/content/pkg/COMPS-11720/pdf/COMPS-11720.pdf.
2 Centers for Medicare & Medicaid Services, "Implementing FISS Updates to Accommodate Section 603 Bipartisan Budget Act of 2015 – Phase 2," MLN Matters® Number: MM9907, accessed August 17, 2023, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9907.pdf.
3 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program, 82 Fed. Reg. 52,976, 53,026 (Nov. 15, 2017), https://www.govinfo.gov/content/pkg/FR-2017-11-15/pdf/2017-23953.pdf.
4 Centers for Medicare & Medicaid Services, *The Provider Reimbursement Manual – Part 1*, accessed June 15, 2023, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.

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