mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

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

MLN Matters Number: SE19007

Related Change Request (CR) Number: 9613; 9907

Date: March 26, 2019

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 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 to enforce the requirements in the Medicare Claims Processing Manual, Chapter 1, Section 170, which describes Payment Bases for Institutional Claims. These requirements are not new requirements. The Centers for Medicare & Medicaid Services (CMS) discussed these requirements 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-NetworkMLN/MLNMattersArticles/Downloads/MM9613.pdf and https://www.cms.gov/Outreach-andEducation/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. For Medicare Physician Fee Schedule (MPFS) and OPPS payments to be accurate, CMS uses the service facility address of the off-campus, outpatient, provider-based department of a hospital facility 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-excepted 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.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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 must 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 provided in a Medicare enrolled location. The validation will be exact matching based on the information 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 reports 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 any services on the claim were rendered at more than one of the campus locations of a multi-campus provider that is not the main billing provider address, providers should report the service facility address in loop 2310E if all of the service facility addresses are different from the billing provider address in loop 2010AA (or in DDE MAP 171F screen for DDE submitters) from the first registered campus encounter of the "From" date on the claim.
- If any services on the claim were rendered at one of the campus locations of a multi-campus provider that is not the main billing provider address and services were also

rendered at other off-campus department practice locations, providers should 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 in loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

- If no services on the claim were rendered at the billing provider address or any campus location of a multi-campus provider, providers should report the service facility address in loop 2310E (or in DDE MAP 171F screen for DDE submitters) from the first registered department practice location 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.....


        P R O V I D E R   P R A C T I C E   L O C A T I O N   A D D R E S S
  ADDRESS 1: .......................................................


  ADDRESS 2: .......................................................


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

Line Level Information:

In the CY 2015 OPPS Final Rule (79 FR 66910-66914), 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 of a hospital. CMS added this 2-digit modifier 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-excepted 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 you to report the PN modifier 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.

New Practice Location Screen Available in DDE

CMS issued instructions to the Fiscal Intermediary Shared System (FISS) maintainer to make the practice location address screen received from the PECOS 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. Providers can compare what is on file with PECOS for their practice locations to ensure that their claims submitted for their practice locations is an exact match.

The PECOS information has been transmitted into the FISS and a comparison of claims with the PECOS information is made when the Provider Practice Location Address is completed for a claim being processed. Providers can access this inquiry screen by going into the Inquiry Menu MAP1702 in DDE and selecting “1D”.

```
MAP1702
                            INQUIRY MENU

       BENEFICIARY/CWF          10     ZIP CODE FILE           19
       DRG  (PRICER/GROUPER)    11     OSC REPOSITORY INQUIRY  1A
       CLAIM SUMMARY            12     CLAIM COUNT SUMMARY     56
       REVENUE CODES            13     HOME HEALTH PYMT TOTALS 67
       HCPC CODES               14     ANSI REASON CODES       68
       DX/PROC CODES ICD-9      15     CHECK HISTORY           FI
       ADJUSTMENT REASON CODES  16     DX/PROC CODES ICD-10    1B
       REASON CODES             17     CMHC PAYMENT TOTALS     1C
       INVOICE NO/DCN TRANS     88     PROV PRACTICE ADDR QUER 1D


     ENTER MENU SELECTION:   1D
```

The following display is made for each provider NPI on file. Providers can select the line they wish to view which matches the service facility being billed. PF6 to scroll forward for addition practice locations on file for their NPI.

```
MAP1AB1
         SC
                                                     MNT:
NPI 1234567890     OSCAR
                               PRAC         PRAC
SEL   NPI          OSCAR       EFF DT       TERM DT     ADDRESS         ZIP
___ 1234567890  ABCDEF       07011966    123102010   1234 MAIN ST    123456789
___ 1234567890  ABCDEF       01012011    123119999   1236 MAIN ST    123456789
 S  1234567890  ABCDEF       07012011    123119999   1239 MAIN ST    123459111
___ 1234567890  ABCDEF       01012018    123119999   666 ELM ST      123459666




    PLEASE MAKE A SELECTION, ENTER NEW KEY DATA, OR PRESS PF3 TO EXIT

PRESS PF3-EXIT PF5-SCROLL BKWD PF6-SCROLL FWD
```


CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

The following display is made for each practice location on file. Providers can PF6 to scroll forward for additional practice locations on file.

```
MAP1AB2
          SC
                                                          MNT:
NPI 1234567890    OSCAR  ABCDEF

PRAC EFF DT 07012011             PRAC TERM DT     123119999
PRACTICE LOCATION KEY  00000000000000000000
OTHER PRACTICE Y
TYPE OF PRACTICE
ADDRESS 1 1239 MAIN ST
ADDRESS 2
CITY ANYTOWN                           STATE AA    ZIP 123459111
NPI EFF DT             07012011   NPI TERM DT        123119999




PRESS PF3-EXIT PF6-SCROLL FWD PF7-PREV
```

National Testing

Round 1 Testing

During the week of July 23, 2018, through July 30, 2018, CMS performed a national trial activation of the 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.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network

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 conducted a second round of national testing in November 2018. Providers should have used 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.

Round 3 Testing

Prior to conducting round 3 testing, CMS 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. CMS has postponed full production implementation for three additional months to allow time for providers to adjust to the new practice location screen. CMS will continue with additional round(s) of testing to ensure that we have a smooth implementation of the edits. CMS plans to conduct a June 2019 national testing to ensure providers have used the new practice location screen tool and made necessary claims submission updates to their systems.

Full Production

After the national test in June 2019 is completed, CMS will review the results. CMS has full production implementation until July 2019. CMS may continue with additional round(s) of testing to ensure that we have a smooth implementation of the edits.

Once the July 2019 Quarterly release is 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 2½ 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.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES Medicare Learning Network®

DOCUMENT HISTORY

Date of Change	Description
March 26, 2019	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 2018 American Medical Association. All rights reserved.

Copyright © 2013-2019, the American Hospital Association, Chicago, Illinois. Reproduced by CMS 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. 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.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES Medicare Learning Network®