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Paying PBDs under Part B:

Certification and Payment Issues in Provider-Based Outpatient Departments

PCG Software, Inc.
7065 W. Ann Road, # 130-549
Las Vegas, NV 89130
(877) 789-1291
www.pcgsoftware.com

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Introduction

For those who interact with Medicare claims in hospital outpatient settings, a significant amount of attention and some concern resulted from certain provisions in Section 603 of The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).[1] This attention has specifically been directed to two features of the legislation and the regulations and guidance that have accompanied it. For one, there remains a general lack of understanding over the "certification process" for establishing a hospital department as "provider based." More importantly, there is a second, more immediate, concern over the legislation's provisions governing Medicare's payments to these departments and how to comply with them. On both fronts the new rules continue to raise questions among institutional providers, professionals delivering services in those departments, and other claims stakeholders. The purpose of this article is to review these two issues and, hopefully, to clarify and put into perspective this aspect of MACRA.

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[1] Technically three recent Congressional Acts: the Budget Act of 2015, the 2016 MACRA statute (esp. Section 603) and, most recently the 21st Century Cures Act provide the statutory framework for the regulatory changes affecting provider-based departments.

In the 2017 OPPS Final Rule, the regulations outline the scope of the new rules and any applicable exemptions. They also provide the requisite technical guidance for implementing Section 603's regulations as they pertain to billing and payment of these services.

This overview of these rules is in two parts. The first part discusses provisions related to the new rule's scope and applicability. The second part looks at billing and payment.

Provider Based Defined

As defined by Medicare, provider-based entities are: ***"a provider of health care services… that is, either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider."*** Such entities, in our case provider-based hospital outpatient department, have various locales. They can be physically located either on the facility's grounds (e.g., "on-campus") or located at a geographically-separated location from the main provider (e.g., "off-campus"). Their "situs," as will be explained below, is an important, yet confounding, feature of the Section 603 of MACRA's "Interim Rules" that provide the regulatory guidelines which determine the payment level for the facility component in many of these departments[2].

[2] In this document the term "Interim Rule" refers to the Interim Final Rule outlining the regulatory guidance for section 603 of MACRA as supplements by certain provision in the 212st Cures Act of 2016 provisions in this latter legislation, for example, clarified certain technical issues regarding compliance with the grandfathering revisions of the MACRA Section 603 regulations.

Provider-Based Certification

The process by which an outpatient department of a hospital, and indirectly, the providers who deliver services in them, gain certification of its "Provider-Based Status" is described in Federal regulations 42 CFR 413.65. The process for gaining certification is voluntary and is self-initiated by the sponsoring hospital.[3] Said another way, a hospital outpatient department or other hospital affiliated entity, for example a hospital-owned off-site diagnostic imaging facility, is not mandated to prospectively obtain it. However, if the entity fails to gain certification, but bills as provider based, those billings face the risk of being recouped by CMS at a subsequent date. The formal requirements that allow a hospital to establish provider-based entities are summarized as follows:

- **The sponsoring hospital and the departments must meet the general conditions required of any organization participating in the Medicare Program. For example, single licensure operation, conformance to federal patient anti-dumping restrictions, EMTALA adherence, etc.**
- **All facility billings to be performed under the main institution's Medicare's Billing Number**
- **Staff reporting relationships, financial policies and medical policies including medical records, must be uniformly integrated with the hospital's policies and procedures and operations.**
- **The departments must adhere to beneficiary and public disclosure requirements. Any patient liabilities must be clearly and fully disclosed on the beneficiary's bills.**

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[3] Note that not every hospital department can be expected to seek certification as provider based. Moreover there are certain other hospital-based entities that are specifically prohibited by CMS regulations from pursuing this certification. An example of the former is a remote location of a hospital satellite facility. Illustrations of the latter would be a hospital campus located End Stage Renal Disease Facility or a non-clinical, non-revenue producing department of a hospital, for example its Medical Records Department.

There are two principal documents which memorialized the process by which a hospital obtains provider-based certification for an eligible clinical department. The process is typically channeled through the institution's designated Medicare Administrative Contactor. The documents are; (1) A Provider-Based Attestation Statement which is the initial submission and (2) Submission of Medicare's Enrollment Form 855A. In the latter document, all provider-based departments and their locations must be indicated, and each must include specification of any services that were furnished by the department as OPPS covered services at that site as of November 1, 2015. Certifications are not initially time-bound, but they are not "evergreen," and can be subsequently withdrawn by CMS.

Provider-Based Billing

Provider-based billing has been described as a billing process for services to "correctly" allocate a department's facility costs where more than one type of provider activity is taking place in the same facility so as to comply with Medicare's inpatient cost reporting methodology.[4] However, it's most important consequence for hospitals is that other Medicare regulations allow outpatient departments certified as provider based to bill and to be paid at rates set by Medicare's Outpatient Prospective Payment System.[5] Medicare's payments to these facilities are materially higher than they would be if the department's "technical services" were paid at office-based payment rates. As the number of departments "off-campus" from the

[4] Medicare's determination of hospital department's overhead costs has long made use of an intricate step-down cost accounting system for allocation of their spreading the overhead cost of operation across departments.

[5] It is important to note that while the ability to engage in provider-based billing is a defining characteristic of a department that gains certification as provider based, certification is not a payment method akin to DRGs or RBRVS based payments. It a CMS sanctioned relationship between a hospital and the Provider-Based entity that allows a specific billing method to be used.

hospital has grown, the size in disparities in these two facility payment forms have added to Medicare's costs.[6]

Provider-Based Payment

Section 603 of MACRA and the Interim Rule guidance that articulates its payments require certain provider-based departments to be reimbursed at reduced rates. In CMS's view it is these rates that more closely approximates the Department's "true" facility costs. Let's examine these new rules and how they impact the department's Medicare payments.

First, it's important to note that the changes required in Section 603 only impact ***the facility component*** of provider-based department payments. Providers in the department delivering professional services are not affected. Their Medicare allowance amounts continue to be paid at Medicare Physician Fee Schedule's "professional services in facility rates." Second, any outpatient department providing "dedicated emergency services" is excluded from the new payment rules.[7] Third, the payment reductions only apply to CMS specified "off-campus" provider-based departments. As we shall see, an intricate set of rules has been issued by CMS to make these "campus" determinations. Fourth, "legacy" provider-based departments" have been granted "grandfathered protections" that exempt them from the new reimbursement rules. Finally, CMS has revised HCPCS code modifiers and place-of-service codes to implement the process. Table 1 summarizes some of the main points of the Interim Rules regarding the classification, payment, and reporting requirements for provider-based departments.

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[6] This is a direct product of the acquisition of office-based physician practices by hospitals so that they can expand their "distribution systems" so as to gain share in the outpatient services market.

[7] That is, any provider-based department that is either; (a) State licensed as an emergency room, or (b) Publicly holds it out to be a provider of emergency services, or (c) Annually treats one-third or more of its patients on an unscheduled urgent or emergent basis.

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Table 1: 2017 Interim Rules: Provider-Based Department Payment and Reporting

Physical Location	CMS Location Specification	"Campus" Designation	PBD Services Status	Facility Pay Method	Prof Services Pay Method	Required Use of Modifiers PO or PN?	Grandfather Rule Applies?
MAIN HOSPITAL LOCATION	***At The Main Hospital***						
	PBD Located in the Main Hospital Building(s)	"On Campus" Provider-Based Department	NA	OPPS	MPFS(f)	NO	NA
	PBD Located Outside of the Main Hospital Building but within 250 yards or less of it	"On Campus" Provider-Based Department	NA	OPPS	MPFS(f)	NO	NA
	PBD Located Outside of the Main Hospital Building & Over 250 yards away	"Off Campus" Provider-Based Department	NOT EXCEPTED *	INTERIM FEE	MPFS(f)	PO* or PN	YES*
OTHER SERVICE AREA LOCATION	***At A Remotely Located Related Hospital***						
	At A Remote Hospital Location Other Than The Main Hospital Campus						
	PBD Located Outside the Building of a Remotely Located (>35 mi.) Other Hospital *Controlled By Main Hospital Within 250 yards of Its Main Building*	Excepted "Off Campus" Provider-Based Department	EXCEPTED	OPPS	MPFS(f)	NO	YES
	PBD Located Outside the Building of a Remotely Located (>35 mi.) Other Hospital *Controlled By Main Hospital Over 250 yards of Its Main Building*	Excepted "Off Campus" Provider-Based Department	EXCEPTED	OPPS	MPFS(f)	NO	YES
	At A Unrelated Satellite Located "Other Hospital"						
	At a Remote Location Other Than Main Hospital Campus and Co-located With An Unrelated Hospital						
	PBD Located Within the Building of a Remotely Located (>35 mi.) Unrelated Hospital Within Its Main Building	Excepted "Off Campus" Provider-Based Department	EXCEPTED	OPPS	MPFS(f)	NO	NA
	PBD Located Within the Building of a Remotely Located (>35 mi.) Unrelated Hospital But Within 250 yards of Its Main Building	Excepted "Off Campus" Provider-Based Department	EXCEPTED	OPPS	MPFS(f)	NO	NA
	PBD Located Within the Building of a Remotely Located (>35 mi.) Unrelated Hospital But Not Within 250 yards of Its Main Building	"Off Campus" Provider-Based Department	NOT EXCEPTED	INTERIM FEE	MPFS(f)	NO	NA

Notes: The * indicates would be applicable if the Provider-Based Department was paid on OPPS System prior to November 1, 2015. MPFS(f) refers to the Medicare Physician Fee Schedule professional services in a facility amount. OPPS is payment based on Medicare Outpatient Prospective Payment System. INTERIM indicates that the PBD fees are calculated based on the Final Interim Rule. "Excepted "indicates that Facility fees for the provider-based department's services continue to be paid at the OPPS rate.

When the "on-campus" or "off-campus" designations in Table 1 are mapped to the payment rules, the scope of the reimbursement consequences of an "off-campus" designation is significantly mitigated. Being located away from the hospital (e.g., "off-campus") does not always pay the department at the reduced facility Interim Rate.[8] The scope of the reporting requirements associated with the mandatory use of modifiers PO and PN is also very narrow. Only claims from non-grandfathered provider-based departments categorized as "off-campus" are affected.[9]

Based on Table 1 let's walk through the alternative payment scenarios generated by the rules for Provider-Based Departments (i.e., on campus, off campus, remote hospital location - main hospital location, grandfathered - non-grandfathered, use modifiers - don't use modifiers) and try to sort out the consequences of the various scenarios.

- ***If the Provider-Based Department (PBD) is located in the Main Hospital or within 250 yards of its principal building*—Then the PBD is considered as "on-campus." Being "on-campus," its services are "excepted." Facility fees continue to be paid on the prevailing OPPS rates. Since modifiers PO and PN do not apply to "on-campus" location, neither modifier applies. Professional providers delivering services are paid at the professional services "facility" rates using the Medicare Physician Fee Schedule.**

- ***If the Provider-Based Department is located greater than 250 yards from the principal building of the Main Hospital*—Then the PBD is considered as "off-campus."**

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[8] ."Interim Rate" refers to the new reduced facility fee schedules allowance amounts that are applicable to off-campus non-excepted provider-based department services.

[9] The grandfathering rule exemption applies to any off-campus provider-based department that was reimbursed under the Medicare Outpatient Prospective Payment System prior to November 1 of 2015. These departments are exempted from the facility payment charge. Medicare facility payments to these grandfathered provider-based departments continue to be made at the full OPPS amount.

- **If the "off-campus PBD *is "grandfathered,"* its services are "excepted." Facility fees continue to be paid at the prevailing OPPS payment rate. Modifier PO must be reported for these "off-campus" and "excepted" services.**

- **If the off-campus PBD *is not "grandfathered,"* its services are "non-excepted." Facility fees are reduced and paid based at the Interim Rate. Modifier PN must be reported with the "non-excepted" off-campus services.**

- ***If the Provider-Based Department is located at a Remote Hospital (controlled by a Main Hospital) and is located in, or within, 250 yards of the hospital's principal building*—Then the PBD is not considered to be "on-campus." However, its services are considered to be "excepted." The department is an "excepted off-campus provider-based department." Its facility fees are paid at OPPS payment rates. The exception applies whether the Department is, or is not, "grandfathered." Modifiers PO and PN are not reported.[10]**

- ***If the Provider-Based Department is Located at a Remote Hospital (controlled by a Main Hospital) sited more than 250 yards of that hospital's principal building*—Then the PBD is considered to be "off-campus." Its services are not considered to be "excepted." Facility fees are reduced and paid at the Interim Rate. However, if the provider-based department is "grandfathered," the facility fees would continue to be paid at the OPPS payment rates. Modifiers PO and PN are not reported.**

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[10] In its Q&A Sheet on PBDs the following interrogatory appears; Question: Should the PO modifier be applied to off-campus PBDs that are provider based to a main hospital if they are located in, or on the campus, of a remote location of the main hospital? Answer: The modifier codes do not apply to services physically provided at remote hospital locations of the applicable main hospital or on the campus of a remote location of the applicable main hospital. A remote location of the hospital as defined under 42 CFR 413.65Pub 100-04 Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 3685 Date: December 22, 2016 Change Request 9930.

- ***If the Provider-Based Department is Located at the Remote Satellite Facility inside or Within 250 yards of the remote "Other Hospital's" main building***[11]**—Then *the PBD is considered to be "off-campus." However, the department's services are considered to be "excepted." The Department is classified as an "excepted" off-campus Provider-Based Department. Facility fees are paid at the OPPS payment rates. The exception applies regardless of whether the Department is, or is not, "grandfathered." Modifiers PO and PN are not reported.***

- ***If the Provider-Based Department is located at the Remote Satellite Facility greater than 250 yards from its Main Building***—**Then the PBD is considered to be "off-campus." It is a "non-excepted, off-campus provider-based department." Facility fees are paid on the reduced Interim Rate. If the non-excepted off-campus department is "grandfathered," facility fees continue to be paid on the OPPS payment rates. Modifiers PO and PN are not reported.**

Non-Excepted Services Facility Rates

Provider-Based Departments subject to changes in their facility reimbursement are paid on "Interim Rate" by way of a special fee schedule. However, at the service code level, most, but not all, of the possible outpatient services deliverable by the department or its providers have the facility component paid using the Interim Rate. Those service codes in the Interim Rate schedule consist of selected code groups extracted from all OPPS APC based services. Listed in

[11] In the Interim Rule implementing the Section 603 regulations, the term "satellite facility" has a special meaning relative to payments for provider-based departments. It designates those provider-based departments controlled by the Main Hospital that reside, in either; (1) The building of a remote unaffiliated hospital, or (2) The department is located in another building on the campus of the un-affiliated hospital.

Table 2 are these codes status groups. Collectively there are 5,380 individual codes.

Table 2: OPPS Services Subject to PBD Interim Rule Fee Schedule and Payment Method

OPPS Code Status	Item/Service Category	OPPS Payment Prior to Section 603 Implementation	MPFS Payment Calculation Adopted in Final Rule
J1	Hospital Part B services paid through a comprehensive APC	Claim-level packaged payment	Paid 50 % of C-APC rate
J2	Hospital Part B services that may be paid through a Comprehensive APC (Observation)	Comprehensive APC Payment	Paid 50% of C-APC rate
Q1	STV-packaged codes	Packaged APC payment if billed on same claim with "S," "T," or "V" procedure	Paid at 50% of APC rate if billed without "S," "T," or "V" procedure; otherwise packaged
Q2	T-packaged codes	Packaged APC payment if billed on same claim with "T" procedure	Paid at 50% of APC rate if billed without "T" procedure; otherwise packaged
Q3	Codes that may be paid through a composite APC	Composite payment when criteria met; otherwise separate APC payment or packaged payment	Paid at 50% of APC rate if composite criteria met; otherwise packaged
S	Procedure or Service, Not Discounted when multiple	Separate APC payment	Paid at 50% of APC rate
T	Procedure or Service, Multiple Procedure Reduction Applies	Separate APC payment	Paid at 50% of APC rate Existing MPFS Multiple Procedure Payment Reduction Policies Apply
V	Clinic Visit	Separate APC payment	Paid at 50% of APC Rate

To develop the allowance amounts for these codes, CMS conducted a study which compared 2016 OPPS payment data from provider-based departments and compared that data with payments for the same

services made under the Medicare Physician Fee Schedule. From this study, general relationships and fee relativities were established between each OPPS code's facility rates and the "technical component" payment made for the office-based matching codes in the Physician Fee Schedule. Based on those comparisons, a "global adjuster" of .50 of the OPPS rate was derived by CMS.[12] This is used to "price" the service codes in the Interim Rate schedule that is used for those provider-based departments subject to fee reductions.

Reporting Provider-Based Department Services

Under the new rules, provider-based departments continue to "split bill" their claims into a professional component and a technical component.[13] These departments also continue to report that facility component on the hospital claim Form UB-04, while providers of professional services continue to report their services on the HCFA 1500 Claim Form.

CMS's implementation of Section 603 now, however, requires departments to comply with a number of billing and code reporting changes that have been made. Those changes require close

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[12] CMS notes that for most services, the same HCPCS codes are used to describe services paid under both the MPFS and the OPPS with two notable exceptions; evaluation and management services, which are reported in MPFS using a total of 10 CPT codes while in OPPS a single HCPCS code G0463 (Hospital Outpatient Clinic Visit) is used. CMS has established payment rates for G0463 based on the OPPS payment rate reduced by the .50. The second exception is for several radiation treatment delivery and imaging guidance services codes.

[13] CMS's original proposal under the MACRA proposal was to eliminate split-billing entirely and only pay the physician or group for non-excepted services. This would have prevented the hospital provider-based departments from billing and receiving payment for a facility fee. That would have raised the issue of how the hospital could recover its overhead costs for the facility. This, in turn, would require the hospital to look to and negotiate with the department's contracted physician. This that has raised a number or thorny legal and contractual concerns.

cooperation between the professional providers who deliver the department's services, those who code these services, and those tasked with establishing and enforcing medical and payment policies in the departments. Typically these are administrative and/or clinical departmental managers.

For one, these managers must closely monitor individual providers who are employed or contracted to provide the professional services in the department to make certain that "correct coding" requirements applicable to "excepted" or "non-excepted" services are followed. While Section 603 did not change the reimbursement levels on professional claims, staff will have to insure that the professional claims reported, conform to the new CMS place of service requirements discussed below. Managers will also have the responsibility to insure that they co-ordinate with other outpatient departments in the facility relative to any "mixed use providers," providers who deliver services to both provider-based and non-provider-based departments.[14]

Date of Service, Place of Service, and Modifiers

In addition to codes and facility rates, three other changes in claims related factors for provider-based departments must be considered. These changes relate to dates of service, place of service and the use of modifiers. All are, of course, a familiar part of the "stuff" of claims. However, the Interim Rules have developed complex rules to implement the new facility payments. These three claims elements must be carefully reviewed.

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[14] "Mixed Use" sites refers to sites that are part provider-based, and part freestanding. CMS is becoming more restrictive in its review and approval of mixed use sites (especially when mixed use is within same suite). CMS position will allow one building to have both, but generally requires a clear separation between them.

Date of Service

Relative to dates-of-service on provider-based claims one "key" requirement is straightforward: that date is November 1, 2015. This is the date of service that "triggers" the expiration of the "grandfathering" provisions in the Interim Rules. A provider-based department whose claims, prior to that date, were paid using the Outpatient Prospective Payment System is "excepted" from the rule compliance and, as was noted earlier, its facility claims continue to be paid at prevailing OPPS rates. That provider-based department and the hospital that sponsors it must, however, take care to maintain the documentation (e.g., claims history), to be able to attest that they were paid accordingly.[15]

Place of Service (POS)

While payments for professional services remain unaffected by the Interim Rules, provider-based departments continue to be responsible for insuring that the correct place of service codes are entered on the claims that providers deliver in the department.[16] This is the case regardless of whether of the relationship between the professional provider and the department is employment based or contractually based. Since location plays an important role in distinguishing between "excepted," and "non-excepted" services, the department has an interest in providing the correct site-of-service information on both facility and professional claims.

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[15] CMS expects hospitals to maintain proper documentation showing which individual off-campus PBDs were billing Medicare prior to November 1, 2015 and to make this documentation available to CMS and its contractors upon request.

[16] Place of service codes are "designators;" they place the service performed at a specific locale. Modifiers are "qualifiers;" their attachment to a code indicates an exception to the standard definition and use of the modified code in this case. If the place of service code POS 19 is on the professional services HCFA 1500 Claim Form, all of those outpatient professional services or supplies reported on the claim were performed off the "hospital's campus. For professional services billing CMS-1500 Claim Forms, eligible professionals are required to include place of service cod POS 19 when the services are rendered in an off-campus outpatient department.

Over the past two years there have been changes in both the modifiers that provider-based departments use and the place of service codes those providers in those departments report. This situation has the potential for creating misunderstandings and potential conflicts between the two. Both of the "key" modifiers submitted in provider-based departments and the place of service codes on the claims that professionals submit are now "campus defined." To clarify this important concept we need to review these reporting changes and their impact on the relationship of place of service codes to these modifiers.

In order to track the professional services delivered in provider-based departments, CMS changed its place of service codes. First, the descriptor of the "legacy code" for outpatient services, POS 22 "Outpatient Hospital," was revised to "On Campus-Outpatient Hospital." To supplement that change, a new place of service code, POS 19, was created. This code was defined as "Off Campus Outpatient Hospital." The professional services in provider-based departments could be differentiated based on an "off-campus/on-campus" distinction. Concurrently, CMS implemented policies changing the definition of the two modifiers (one old, one new) so they could be used for differentiating facility claims based on "campus" criteria.

Modifiers PO and PN

The outpatient modifiers, PO and PN, and the rules prescribing their use are important elements in implementing the new provider-based department payment policy.[17] These modifiers operate at the claims line level to enforce whether the service performed at an "off campus" sited provider-based department is, or is not, an

[17] That is, modifier PO could not be used by what is a significant number of OPPS payable codes (listed in Appendix A and B in the OPPS Payment System) that are not grouped into ASCs. For example, codes for physical therapy procedures and codes for laboratory tests.

"excepted" service. The presence of either modifier triggers, or fails to trigger, a payment change on the claim line.[18]

Just as the two place-of-service codes were used for tracking costs for professional services, CMS initially used the two modifiers to gather cost data. In this case to compare facility costs for outpatient services delivered in off-campus provider-based locations when set against the costs incurred for services delivered in private office-based settings. The focus of the modifiers had changed to now serve as devices to implement the new payment rules.

The Modifier PO's definition was changed from: *"Services, procedures, and/or surgeries furnished at off-campus provider-based outpatient departments," to "Excepted service provided at an off-campus, outpatient, and provider-based department of a hospital."* The change significantly narrowed its application to modifying reported service codes designated as "excepted services" under the Interim Rule so the facility payments for the service is unchanged and is paid at the OPPS rate.[19]

To complement the modifier PO, a new modifier PN, was introduced. This modifier is the mirror image of modifier PO. It was defined as a, *"Non-excepted service provided at an off-campus, outpatient, and provider-based department of a hospital."* When it appears on the UB-04 Claim Form, PN indicates that the service is non-excepted. Per the Interim Rule, this triggers facility payment at the reduced Interim Rule rates.

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[18] When reported on a claims line with multiple modifiers, "correct coding" requires that it must be listed last on the list of modifiers on the claim line.

[19] The modifier PO has several qualifiers. First, it may only be reported on facility claims. Second, it can only be used with codes that fall into an OPPS Ambulatory Payment Classification Group. Finally, PO is not to be reported on provider-based departmental claims generated at remotely located hospitals or remote satellite facilities. To expedite the operation of Final Rule's reimbursement changes, modifier PO's definition was changed.

Reporting Facility Services

Facility claims are reported on Form UB-04. That Form does not record place of service. However, the reduced payments for the facility component are limited to departments' located "off-campus." As such, modifiers PO and PN are the appropriate vehicles for coding this information and then triggering the designed payments. They have the shared characteristics of only being applicable to "off-campus" situations, but they have distinguishing characteristics: Modifier PO modifies the code so it is an "excepted service," while Modifier PN modifies the code to identify it as a "non-excepted service."

However, as we demonstrated earlier, *the rules for the use* of modifiers PO and PN that determine when services are (are not) "excepted" are variable rules and not absolute rules. An "off-campus" provider-based department can be deemed as an "excepted off campus department." If so, all of its services are "excepted," and the facility payment does not change. However, under other conditions, the "off-campus" location does not "except" and facility payments are reduced. Still other rules "except" the services delivered in any "off-campus" provider-based department that is "grandfathered." In those provider-based departments, none of the department's "off-campus" services facility fees are reduced!

To summarize, there is a multiplicity of types of provider-based departments that are in fact generated by the provisions of the Interim Rules. This consideration becomes even more important given the fact that many hospitals may have multiple provider-based departments. Some of those departments may be grandfathered, others are not. Additionally, multi-hospital systems by definition have many hospital locations and may sponsor many satellite facilities.

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Summary and Conclusions

Given the complexities built into the Interim Rules how, at the operational level, can departments with these regulations comply? One possible approach would be to construct a set of decision rules for each possible type of provider department designated by this process, and pay the departments' claims using the various claims components of service code, date of service, place of service, modifier and a more articulated set of situs indicators. However, based on the review and analysis conducted so far, it seems unlikely that, based these claims components alone, a sufficient robust set of provider-based department types could be culled from such a bottom-up approach.

That inventory of provider-based departments must be developed through the coordinated efforts of hospital management. It must be articulated to the individual department level. That effort must be based on documentation from various functional units in the hospital such as provider contracting, regulatory affairs, finance and, most importantly, the clinical and administrative heads of the outpatient departments. The clinical staffs providing services in the outpatient departments must also be involved.

Training and education will, of course, have to be conducted for coders, billing staffs and claims processing. Contract compliance information and the physical of data (e.g., 250 yards) will be part of the effort. All of this must be then be submitted and authenticated, and signed off by the regional CMS-contracted organization responsible for monitoring provider-based entities.

Once developed, this list of provider-based departments and the processing of any payment rules that flow from each will have to be hard-coded into the various administrative clinical and processing systems for each location so the applicable areas can make sure that the payment modifiers are applied.

For now, there are many questions about the future direction of regulations affecting provider-based departments. Given a new Administration and associated changes in the leadership of both Health and Human Services and the Center of Medicare and Medicaid Services, a new direction seems evident. For now, those directions seems committed to the decrease and the simplification of Federal regulations and place a greater reliance of market forces as the vehicle to contain or at least reduce the rate of increase in healthcare costs.

CMS's response to complying with Congressional mandates to address and reform the inequities in Medicare's facilities fee payments in provider-based outpatient departments is not impressive. The lack of consistency, logic, and uniformity in the provider-based payment rules has, to date, painted a picture of a clumsy response of bureaucracy that may be losing its ability to successfully execute the often contradictory program mandates of legislature to whom it is responsible with the tools and resources it has been given. It lacks the capacity to manage and referee a vast government benefits program working in a fragmented highly complex industry where most services are delivered by providers who must also serve their private and institutional financial and interests.

EXAMPLE OF BILLING

UB04 shows facility charges with PO modifier CMS-1500 claim form contains professional component for 99202 and Electrocardiogram reading fee (93010), billed with place of service 19 to indicate outpatient hospital service in an off-campus location

1 Memorial Hospital 123 First Ave Midwest City, AK 12345	2	3a PAT. CNTL # 123456 b. MED. REC. #	4 TYPE OF BILL 13X
		5 FED. TAX NO. xxxxxxxxx	6 STATEMENT COVERS PERIOD FROM 070115 THROUGH 070115

8 PATIENT NAME	9 PATIENT ADDRESS
a Jane Doe	a 345 Main St
b	b Midwest City c AK d 12345 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT
05081900	F	070115	12				01

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0510	Clinic	99202 PO	070115	1	$110.00		
0300	Laboratory	85025 PO	070115	1	$75.00		
0730	EKG	93005 PO	070115	1	$90.00		
0001					$275.00		

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07 01 15	07 01 15	19		99202		1	75 00	1		NPI	XXXXXXXXXX
2	07 01 15	07 01 15	19		93010		1	50 00	1		NPI	XXXXXXXXXX

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EXECUTIVE SUMMARY

- There is a continuing amount of attention and concern regarding provisions in Section 603 of The Medicare Access and CHIP Reauthorization Act of 2015 related to "Provider-Based" Hospital Outpatient Departments.

- Two concerns "stand out." The first is a general lack of understanding of the "certification process" for establishing outpatient departments as "provider based." Of equal, if not greater importance, are concerns over Medicare's new payment requirements and how to comply with them.

- The most important consequence for an outpatient departments' being as provider based, it's that the facility payments it receives are materially higher when compared to the Medicare office-based payments.

- All hospital outpatient departments are not required to obtain a provider-based status. However, if the department fails to do so and it bills as "provider based," those billings may be recouped at a later date by CMS.

- Two documents memorialize the process for obtaining Medicare provider-based certification. The documents are; (1) A Provider-Based Attestation Statement and, (2) Submission of Medicare's Enrollment Form 855A.

- MACRA and its Interim Rule require ***certain*** provider-based departments to be reimbursed at reduced rates that more closely approximates that department's "true" facility costs.

- Medicare reimbursements to providers delivering professional services in provider-based departments are not affected with services continuing to be paid at the Medicare Physician Fee Schedule's professional services in facility rates.

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EXECUTIVE SUMMARY
(continued)

- **Being physically located away from the hospitals campus (e.g., "off-campus") does not result in the provider-based department being paid at the reduced facility Interim Rate.**

- **There are alternative payment scenarios generated by the Interim Rules payment policies governing facility payments to provider-based departments.**

- **Those Provider-Based Departments that are subject to changes in their facility payments are reimbursed on an "Interim Rate" using a special fee schedule. Most, but not all, of the outpatient services are included in this schedule.**

- **Provider-based departments continue to be responsible for insuring that the correct place of service codes are entered on the claims for service that providers deliver in the department.**

- **There have been changes in both the modifiers and the place of service codes provider-based departments report. This situation has the potential for creating misunderstandings. Both the "key" modifiers and the place of service codes are now "campus defined."**

- **Modifiers PO and PN, and the rules prescribing their use, are important elements in the new provider-based department policy. These modifiers can trigger, or fail to trigger, a payment change at the claim line level.**

- **The functionality of modifiers PO and PN aside, *the rules that apply them* are "conditional" rules, and not absolute rules. There *is a multiplicity* of types of provider-based departments generated by the Interim Rules for applying these modifiers.**

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EXECUTIVE SUMMARY
(continued)

- Given the complexities built into the Interim Rules compliance at the operational level, compliance is likely to be challenging.

- It would be difficult to construct a set of decision rules for each possible type of provider department designated by the Interim Rules to pay the departments claims using the various claims components of service code, date of service, place of service, modifier and regulatory compliant site-of-service indicators.

- An inventory of a hospital's provider-based departments is at best being developed through the coordinated efforts of hospital management, and must be articulated to the individual department level. That effort must be based on documentation from various functional units in the hospital such as provider contracting, regulatory affairs, finance and the clinical and administrative heads of the outpatient departments.

- There are many questions about the future direction of regulations affecting provider-based departments given the leadership changes in HHS and CMS.

- CMS's response to complying with legislative mandates to address the inequities in Medicare's facilities fees payments in provider-based outpatient departments has not been impressive. There is lack of consistency, logic, and uniformity and there is an opaqueness in the provider-based payment rules.

- CMS may be losing its ability to successfully execute the often contradictory program mandates of Congress and the Administration to whom it is responsible; with the tools and resources it has been given.