LOCATION MATTERS: GET IT RIGHT OR DON'T GET PAID

Location, location, location - this will be the focus of a Medicare hospital claims processing requirement. Starting in April 2019, CMS will activate billing edits that will Return to Provider ("RTP") any hospital UB-04 claims that identify a service location that is not an exact match to a Medicare enrolled location identified in Provider Enrollment, Chain and Ownership System ("PECOS"). Hospitals need to ensure all off-campus provider-based departments ("PBDs") are separately listed in PECOS. Additionally, hospital billing departments should ensure all UB-04 (CMS 1450) claims accurately identify the location where services are rendered, which should be an exact match to a PECOS enrolled location. Finally, hospitals should perform a broader review of their locations for licensure, accreditation, 340B and other purposes. See below for details.

BACKGROUND

As discussed in a previous article from November 3, 2016, CMS implemented Section 603 of the Bipartisan Budget Act of 2015 ("Section 603"), which established that services at non-excepted (non-grandfathered) off-campus PBDs will be paid under the Medicare Physician Fee Schedule ("MPFS") beginning January 1, 2017 rather than the Outpatient Prospective Payment System ("OPPS") ambulatory payment classification payment amount.

In order for MPFS and OPPS payments to be accurate, Medicare systems use the service facility information identified on the claim to determine the applicable payment method or locality whenever it is present. Medicare systems will also validate the PBD service facility location on the claim to ensure services are being provided in a location that is enrolled on the Form CMS-855A submitted by the hospital and entered into PECOS.

CMS issued alerts in 2016 and 2017 instructing hospitals to correctly identify the off-campus PBD location on the claim, and to update their PECOS enrollment file to ensure all off-campus PBD locations are included. Both alerts stated that, effective January 1, 2017, Medicare Administrative Contractors ("MAC") would RTP any hospital claims submitted with a service facility location that was not included on the CMS 855A enrollment form. However, it has become apparent that these RTP edits were not permanently activated at that time.

In 2018, CMS performed national testing on these edits. During the national testing, CMS learned that many hospitals are not providing the correct service facility location on the claim that produces an exact match with the Medicare enrolled location. In some instances, the hospital incorrectly identified the main campus on the claim; in other instances, the service location on the claim was not an exact match to the PECOS enrolled location. CMS gave examples clarifying the case sensitive nature of this validation process. For example, in PECOS the word entered was "Road" as part of their address, but the hospital entered "Rd" or "Rd." as part of the address on the claim submission. This particular discrepancy would cause a claim to be RTP'd under the edits.

In SE18023, CMS clarified that starting in April 2019, CMS will direct A/B MACs to permanently turn on the edits and RTP claims where the service location on the claim does not exactly match a PECOS enrolled location.

OPERATIONAL CONSIDERATIONS AND PRACTICAL TAKEAWAYS

Hospitals should move quickly to review their PECOS enrollment files, and ensure all hospital locations are identified separately and accurately in PECOS prior to the implementation of the April edits. Hospitals that need to add a new or correct an existing practice location address will need to submit an 855A enrollment application to make these changes. Some MAC enrollment departments can take weeks to approve practice location changes and enter them into PECOS. Thus, hospitals should submit any necessary 855A applications as soon as possible to ensure that PECOS profiles are current in time for the April edits to activate.

Billing staff should identify the Medicare enrolled location where services were rendered on the claim, and make sure it is an **exact match** to the USPS location enrolled in PECOS. It is not appropriate to identify the hospital's main campus on the claim if services were rendered at an off-campus PBD. Starting in April 2019, electronic billers should be able to see PECOS enrolled locations in their billing system to ensure that the exact match of the practice location can be submitted on the claim without spelling errors or variations. Additionally, billing staff should be aware of the PN and PO modifiers and should review instructions in SE 18023 to ensure the proper address(es) are identified on the claim depending on the scenario.

While this guidance highlights the need for consistency between the UB-04 claim and PECOS enrollment file, it is also a reminder for hospitals to perform a comprehensive review across multiple disciplines such as licensing, accreditation, 340B child sites, state Medicaid enrollment, etc. Provider-based locations should be listed with the accreditation agency and, depending on state law, may need to be separately identified on the state license. Medicare enrollment departments can choose to cross reference state licenses or accreditation certifications when approving a new practice location. Thus, when trying to update PECOS enrollment profiles, it is important to make sure all proper documentation can be submitted if requested. In addition, hospitals should ensure that any locations registered as 340B child sites with HRSA are also included in their Medicare enrollment file. Some of these functions are often spread across a hospital system in different departments and may require persistent communication to ensure consistency in all disciplines.

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