

compliance

Outpatient Department or Freestanding Center?

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The United States' healthcare structure is unique among advanced industrialized countries. The United States lacks a uniform system and only recently enacted legislation mandating healthcare coverage for nearly everyone. In 2014, the federal government accounted for 28 percent of healthcare spending, whereas state and local governments accounted for 17 percent.¹

President Obama's Fiscal Year 2016 Centers for Medicare & Medicaid Services (CMS) budget submission to Congress included a proposal to equalize site-of-service payment between hospital outpatient department and physicians' offices. The proposal called for a four-year phase-in period. The projected savings were estimated to be \$29.5 billion over 10 years.

Provider-Based Departments

Before enactment of the Affordable Care Act, hospitals began to purchase physician practices and, by converting these locations to outpatient hospital departments, were able to bill for both the professional fee on the CMS1500 claim form and the facility charges on the UB04 claim form. This meant that hospitals were able to receive the higher Medicare payment by changing the practice setting from physician office to hospital outpatient department. The definitions of hospital departments are listed in Transmittal 57, dated Jan. 29, 2010:²

Definitions related to provider-based status are found at 42 CFR 413.65(a):²

Campus: Means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are

not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

Department of a provider: Means a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program and the personnel and equipment needed to deliver the services at that facility. A department of a provider may not itself be qualified to participate in Medicare as a provider under §489.2 of this chapter, and the Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term "department of a provider" does not include an RHC [Rural Health Center] or, except as specified in paragraph (n) of this section, an FQHC [Federally Qualified Health Center].

Remote location of a hospital: Means a facility or organization that is either created by, or acquired by, a hospital that is the main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital comprises both the specific physical facility that serves as the site

of services for which separate payment could be claimed under the Medicare or Medicaid program and the personnel and equipment needed to deliver the services at that facility. The Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term "remote location of a hospital" does not include a satellite facility as defined in §412.22(h)(1) and §412.25(e)(1) of this chapter.

Provider-based entity: Means a provider of health care services, or an RHC as defined in §405.2401(b) of this chapter, that is either created or acquired by the main provider for the purpose of furnishing health care services of a different type from those of the main provider under which the ownership and administrative and financial control of the main provider, in accordance with the provisions of this section. A provider-based entity comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program and the personnel and equipment needed to deliver the services at the facility. A provider-based entity may, by itself, be qualified to participate as a provider under §489.2, and the Medicare conditions of participation do apply to a provider-based entity as an independent entity.

Provider-based status: Means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or a satellite facility that complies with the provisions of this section.

Hospital providers are required to include all practice locations on the CMS 855A enrollment form. CMS also completed a revalidation process (from March 25, 2011, to March 23, 2015) to ensure that all hospital service facility locations were correctly listed.

Reimbursement for Off-Campus Provider-Based Departments

There are two current classifications for outpatient provider-based departments: excepted and nonexcepted (see Table 1, page 9). On Nov. 1, 2016, the CMS issued the Outpatient Prospective Payment System (OPPS) final rule for calendar year (CY) 2017. The summary for this final rule includes the following:³

Site-Neutral Payments Provision (“Section 603”):

CMS is implementing Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74) in the final rule with comment period and is establishing interim final payment rates under the Medicare Physician Fee Schedule (MPFS) in an IFC [Interim Final Rule with Comment Period] described in more detail below. As required by the statute, the final rule with comment period provides that certain items and services furnished by certain off-campus PBDs [Provider-Based Departments] shall not be considered covered outpatient department services for purposes of OPPS payment and shall instead be paid “under the applicable payment system” beginning January 1, 2017. CMS is finalizing several policies relating to which off-campus PBDs and which items and services are “excepted” from application of the payment changes under this provision and thus will continue to be paid under the OPPS.

Excepted Items and Services:

CMS is finalizing its proposals that certain off-campus PBDs would be permitted to continue to bill for excepted items and services under the OPPS. Excepted items and services are items and services furnished after Jan. 1, 2017:

- *By a dedicated emergency department;*
- *By an off-campus PBD that was billing for covered OPD services furnished prior to Nov. 2, 2015 (i.e., the date of enactment of Section 603 of the Bipartisan Budget Act of*

2015) that has not impermissibly relocated or changed ownership; or

- *In a PBD that is “on the campus,” or within 250 yards, of the hospital or a remote location of the hospital.*

Section 603 of the Balanced Budget Act is specific to any provider-based off-campus departments that were not billed as hospital departments as of Nov. 2, 2015. As a result, CMS established site-specific rates under the MPFS for the technical component of these “new” outpatient departments, which requires the application of an Healthcare Common Procedure Coding System (HCPCS) modifier. For CY 2018, the payment rate for these services will generally be 40 percent of the OPPS rate (with some limited exceptions). Packaging and certain other OPPS policies will continue to apply to such services.

In addition, CMS provided information on outpatient hospital service expansions, relocations, and changes of ownership.

Billing Off-Campus Provider-Based Departments

According to CMS, research literature and popular press have documented the increased trend toward hospital acquisition of physician practices, integration of those practices as a department of the hospital, and the resulting increase in the delivery of physician services in a hospital setting. When a Medicare beneficiary receives outpatient services in a hospital, the total payment amount for outpatient services made by Medicare is generally higher than the total payment amount made by Medicare when a physician furnishes those same services in a freestanding clinic or in a physician’s office.

To identify—and correctly reimburse—off-campus provider-based outpatient departments, CMS has created two HCPCS Level II modifiers. One modifier identifies those departments that meet the criteria for full OPPS reimbursement, and the other modifier identifies those departments subject to section 603 of the Balanced Budget Act of 2015 that will receive a reduction from the full OPPS payment.

In the CY 2015 OPPS Final Rule, CMS created an HCPCS modifier for hospital

claims that was to be reported with every code for outpatient hospital items and services furnished in an off-campus PBD of a hospital:

- **PO:** Excepted service provided at an off-campus, outpatient, provider-based department of a hospital.

Reporting of this modifier was voluntary for CY 2015 and became mandatory on Jan. 1, 2016. Of note, the modifier does not apply to critical access hospitals (CAHs) because CAHs are not paid through the OPPS.

CMS also publishes a list of frequently asked questions regarding modifier PO, which includes the following:⁴

Q: *Should the PO modifier be applied for drugs or laboratory services?*

A: *The determinative factor is whether or not the item or service is being paid through the OPPS. If an item or service is being provided by an applicable provider and is being paid through the OPPS, then the PO modifier should be applied.*

For instance, a drug with an OPPS status indicator of “K” or a laboratory test that is packaged into an OPPS service should have the PO modifier applied. If a service is not paid through the OPPS, such as a laboratory test paid separately through the Clinical Laboratory Fee Schedule, it should not have the PO modifier applied.

Note that the Medicare Claims Processing Manual Chapter 4 20.6.11 was updated in July 2015 to read: “This modifier is to be reported with every HCPCS code for all outpatient hospital items and services furnished in an off-campus provider-based department a hospital.”

As the modifier PO definition states, this modifier is only reported for “excepted” services, such as those services paid in full under the OPPS. With respect to non-excepted items and services, MLN Matters MM9930 provides the following:⁵

In accordance with the Social Security Act (Section 1833(t)(21)), as added by Section 603 of the Bipartisan Budget Act of 2015 (Pub. L. 114-74), CMS has 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

Table 1. Current Classifications for Outpatient Provider-Based Departments

Excepted	<p>An off-campus outpatient provider-based department billing for covered services prior to Nov. 2, 2015</p> <p>Requires the application of an HCPCS modifier on codes for covered services</p> <p>A dedicated emergency department</p> <p>An on-campus provider-based department</p> <p>Reimbursed under the OPPS</p>
Nonexcepted	<p>An off-campus outpatient provider-based department billing as a hospital location after Nov. 2, 2015</p> <p>Requires the application of an HCPCS modifier on codes for covered services</p> <p>Reimbursed at 40 percent of the OPPS allowance (payment is actually made under the Medicare Physician Fee Schedule)</p>

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 for non-excepted items and services. The use of modifier “PN” will trigger a payment rate under the Medicare Physician Fee Schedule. CMS expects the PN modifier to be reported with each non-excepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services.

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 and services furnished. Use of the off-campus provider-based department (PBD) modifier became mandatory beginning January 1, 2016.

CMS would not expect off-campus PBDs to report both the PO and PN modifiers on the same claim line. However, if services reported on a claim reflect items and services furnished from both an excepted and a non-excepted off-campus PBD of the hospital, the PO modifier should be used on the excepted claim lines and the PN modifier should be used on the non-excepted claim lines.

The modifier is:

- **PN:** Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital.

Professional Billing in Off-Campus Provider-Based Departments

Professional billing reports one of the following place of service codes on the CMS1500 claim form, which differentiate between on-campus and off-campus departments:⁶

- **19: Off-Campus Outpatient Hospital:** A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **22: On-Campus Outpatient Hospital:** A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

There is no professional reimbursement differential for services reported on the CMS1500 claim form; the physician is

reimbursed the same allowance regardless of whether the service is excepted or non-excepted.

Freestanding Centers Owned or Operated by Hospital

Though some facilities or practices are purchased by the hospital with the intent of becoming hospital departments, there are also situations where the hospital purchases an office or freestanding treatment center and continues to operate the facility as a physician office. These units are considered to be wholly owned or wholly operated by one or more hospitals but bill on the CMS1500 professional claim form.

An entity is considered to be “wholly owned or operated” by the hospital if the hospital is the sole owner or operator. A hospital need not exercise administrative control over a facility in order to operate it. A hospital is considered the sole operator of the facility if the hospital has exclusive responsibility for implementing facility policies (i.e., conducting or overseeing the facility’s routine operations), regardless of whether or not it also has the authority to make the policies.

When freestanding entities are wholly owned or wholly operated by a hospital, technical services performed up to 3 days prior to patient admission to the hospital are included on the inpatient hospital bill. According to the *Medicare Claims Processing Manual*, chapter 4:⁷

Diagnostic services (including clinical diagnostic laboratory tests) provided to a beneficiary by the admitting hospital, or by an entity wholly owned or wholly operated by the admitting hospital (or by another entity under arrangements with the admitting hospital), within 3 days prior to and including the date of the beneficiary’s admission are deemed to be inpatient services and included in the inpatient payment, unless there is no Part A coverage. For example, if a patient is admitted on a Wednesday, outpatient services provided by the hospital on Sunday, Monday, Tuesday, or Wednesday are included in the inpatient Part A payment.

For outpatient nondiagnostic services furnished on or after June 25, 2010, all outpatient nondiagnostic services, other than

ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the date of a beneficiary's inpatient admission are deemed related to the admission and thus must be billed with the inpatient stay.

Also, outpatient nondiagnostic services, other than ambulance and maintenance renal dialysis services, provided by the hospital (or an entity wholly owned or wholly operated by the hospital) on the first, second, and third calendar days for a subsection (d) hospital paid under the Inpatient Prospective Payment System (IPPS) (first calendar day for non-subsection (d) hospitals) preceding the date of a beneficiary's inpatient admission are deemed related to the admission and thus must be billed with the inpatient stay, unless the hospital attests to specific nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary's admission) by adding a condition code 51 (definition "51—Attestation of Unrelated Outpatient Non-diagnostic Services") to the separately billed outpatient non-diagnostic services claim. Beginning on or after April 1, 2011, providers may submit outpatient claims with condition code 51 for outpatient claims that have a date of service on or after June 25, 2010.

The Medicare Claims Processing Manual, Chapter 12, adds:⁸

CMS has established HCPCS payment modifier PD (diagnostic or related nondiagnostic item or service provided in a wholly owned or operated physician office to a patient who is admitted as an inpatient within 3 days) and requires that the modifier be appended to the physician preadmission diagnostic and admission-related nondiagnostic services, reported with HCPCS/Current Procedural Terminology (CPT) codes, which are subject to the 3-day payment window policy.

The wholly owned or wholly operated physician's office will need to manage their billing processes to ensure that they bill for their physician services appropriately when a related inpatient admission has occurred. The hospital is responsible for notifying the practice of an inpatient admissions for a patient who received services in a wholly

owned or wholly operated physician office within the 3-day (or, when appropriate, 1-day) payment window prior to the inpatient stay. The modifier is effective for claims with dates of service on or after January 1, 2012. Entities have the discretion to apply these policies for claims with dates of service on and after January 1, 2012, but shall comply with these policies no later than July 1, 2012. When the modifier is present on claims for service CMS shall pay:

- Only the Professional Component (PC) for CPT/HCPCS codes with a Technical Component (TC)/PC split that are provided in the 3-day (or, in the case of non-IPPS hospitals, 1-day) payment window, and
- The facility rate for codes without a TC/PC split.

According to a related Frequently Asked Questions document published by CMS:⁹

Section 102 of Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (PACMBPRA) significantly broadened the definition of related nondiagnostic services that are subject to the payment window to include any non-diagnostic service that is clinically related to the reason for a patient's inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same. PACMBPRA made no changes to application of the 3-day (or 1-day) payment window policy to diagnostic services. Application of the payment window policy to diagnostic services is unchanged since 1998.

The 3-day payment window applies to services provided on the date of admission and the 3 calendar days preceding the date of admission that will include the 72 hour time period that immediately precedes the time of admission but may be a longer than 72 hours because it is a calendar day policy.

The technical component for all diagnostic services and those direct expenses that otherwise would be paid through non-facility practice expense relative value units for nondiagnostic services related to the inpatient admission, provided by a wholly owned or wholly operated entity within the payment window, are considered hospital costs and must be included on the hospital's bill for the inpatient stay. Medicare will pay the wholly owned or wholly operated entity through the Physician Fee Schedule for the professional

component (PC) for service codes with a Technical/Professional Component (TC/PC) split that are provided within the payment window, and at the facility rate (i.e. exclusive of those direct practice expenses that are included in the hospital's charges) for service codes without a TC/PC split.

A wholly owned or wholly operated Ambulatory Surgical Center (ASC) would use the modifier PD to identify outpatient physician or practitioner services subject to the 3-day (or 1-day) payment window.

The modifier is:

- **PD:** Diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days.

Summary

Medicare has different payment systems to pay for services provided on an outpatient basis. In summary:

- Medicare pays for physician professional services provided in a physician's office under the Medicare Physician Fee Schedule.
- If that same service is provided in a hospital setting, Medicare pays the professional component to the physician and also pays a facility fee under the hospital's OPSS.
- When Medicare pays an MPFS professional fee and an OPSS facility fee, the total payment is typically higher than if the service was provided and billed under the PFS only. As a result, section 603 of the Balanced Budget Act of 2015 implemented different payment systems, based on the nature of the outpatient facility.
- Excepted off-campus outpatient provider-based department services are reimbursed under the OPSS. The hospital reports modifier PO on each code billed on the UB04 claim form and the physician reports place of service 19 on the CMS1500 claim form.
- Nonexcepted off-campus outpatient provider-based services are generally reimbursed at 40 percent of the OPSS allowance for CY 2018. The hospital reports modifier PN on each code billed on the UB04 claim form and the physician

reports place of service 19 on the CMS1500 claim form.

- Freestanding centers or physician offices that are wholly owned or wholly operated by one or more hospitals must append modifier PD to services performed 1 to 3 days prior to patient admission in one of the owner hospitals. Medicare will only reimburse professional services during this 3-day period; the hospital should include the technical charges on the claim for inpatient services.

According to a MedPAC report to Congress on Medicare Payment Policy in May 2017, the goal of Medicare payment policy is to get good value for the program's expenditures.¹⁰ This means maintaining beneficiaries' access to high-quality services while encouraging the effective use of resources. The reimbursement challenges affecting hospital outpatient departments are one aspect of delivery system reforms that focus on high-quality care, better care transitions, and more efficient provision of care. **OI**

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