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Compliance Today - October 2023

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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

under MPFS as they would in a hospital outpatient department.