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CMS Is Validating Service Locations, Another Good Reason for Internal PBD Audits

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The use of modifier PO instead of PN on claims for services performed at an off-campus provider-based department (PBD) is worth eyeballing because it may generate overpayments. Hospitals could be reversing them without considering the compliance ramifications and the fact that this mistake may become more transparent now that CMS turned on validation edits Aug. 1 that will reject Medicare claims for services provided at off-campus PBDs if their addresses on claims aren't a perfect match with their addresses on 855A enrollment forms or hospitals with multiple service locations don't report the correct place where services were provided on claims.

The edits are intended to help Medicare pay off-campus PBDs accurately, CMS said in a revised version of an MLN Matters released Dec. 7, which has new information on verifying and updating service locations and using claim modifiers.[1] CMS is watching the way hospitals report practice locations to distinguish between non-excepted, off-campus PBDs, which are paid significantly less for services than excepted, off-campus PBDs. To make sure Medicare knows which is which, non-excepted locations are required to report claim lines with a PN modifier, which triggers 40% of the outpatient prospective payment system (OPPS) payment versus the PO modifier, which triggers the full OPPS payment rate.