
# The Pending Impact of 2020 CMS OPPS Validation Edits and Court Ruling Impact on Provider Pricing

Janett Checo, Senior Principal, Solutions Expert, nThrive

Speaker Introduction

# Janett Checo

Senior Principal Solutions Expert, nThrive Claims Management

**Janett has more than 35 years of billing experience and has worked across all areas of the revenue cycle including coding, compliance, ANSI and paper claim requirements. She has been with nThrive over 13 years and spent over 10 years of her career dedicated to the build of our Claims Management Edit library and has extensive knowledge of our products and clients.**

Prior to joining nThrive, Janett was the Director of Revenue Cycle at HCA for 12 years. She also worked as the Director over Patient Business Services for TX, OK, AR at American Medical Response. In addition to her experience with facilities, she has also managed multi-physician practices and has strong background in the ambulatory space. Janett is a respected expert across the Revenue Cycle and works closely with CMS and other payers nationwide as an advocate for nThrive providers.

CMS and Provider Based Departments Overview

Service Facility Reporting – ANSI Standard language

CMS Specific Requirements for Service Facility Reporting

Timeline Overview of CMS Reporting Requirements

Upcoming CMS Validation Edits

Court Decision Impact on Reimbursement and Claims

Frequently Asked Questions

# CMS and Provider Based Departments Overview

Billing Provider & Service Facility Reporting

# CMS Definition

- **Provider Based Facilities**
  - Provider-based clinics are owned and operated by single entities referred to as "main providers." The clinics may be on the same campus as the main provider, or located off-campus.
  - Primarily a Medicare definition –
    - Clinics share the NPI of the Main Campus Location = Billing Provider
    - Clinics must be enrolled as departments and locations under the Billing Provider NPI and associate to the Medicare PTAN = Service Facility location
    - Off-Campus locations required to bill with either PO, PN or ER modifier
    - Service Facility reporting expected when all services performed at the off-campus location.

http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec413-65.pdf

# CMS Billing Requirements Summarized

- **Provider-based clinics must treat all Medicare patients as hospital outpatients for billing purposes:**

- **UB-04 Requirements**
  - Type of bill (TOB) 13X or 85X
  - Append appropriate HCPCS, subject to correct coding initiative (CCI) edits
  - Effective January 1, 2016, modifier PO must be appended to all items and services paid under Outpatient Prospective Payment System (OPPS) rendered in an off-campus outpatient department
  - Effective January 1, 2017, modifier PN must be appended to all items and services paid under Medicare Physician Fee Schedule (MPFS) rendered in an off-campus outpatient department
  - Include professional services for clinics based within a CAH Method II
  - Line item dates of service

- **CMS-1500 Claim Form Requirements**
  - Bill professional services
  - Include place of service (POS) 19 when the service are rendered in an off-campus outpatient department
  - Include POS 22 when the services are rendered in an on-campus outpatient department

http://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec413-65.pdf

# Billing Provider & Service Facility Reporting

## Billing Provider 2010AA
### – Main Campus

- 16) Q: Please explain what is required in the 2010AA Loop?
- A. 5010 requires the submission of a physical street address in the 2010AA billing provider loop.

## Service Provider 2310E Inst 837I/2310C Prof 837P
### – Off Campus Location

- 18) Q: Medicare is requiring the service facility location, Loop 2310E, when the place of service is home, but is it required for other place of service codes, such as office (11)?
- A. The service facility information is required when the location where the services were rendered is different than the location of the billing provider.

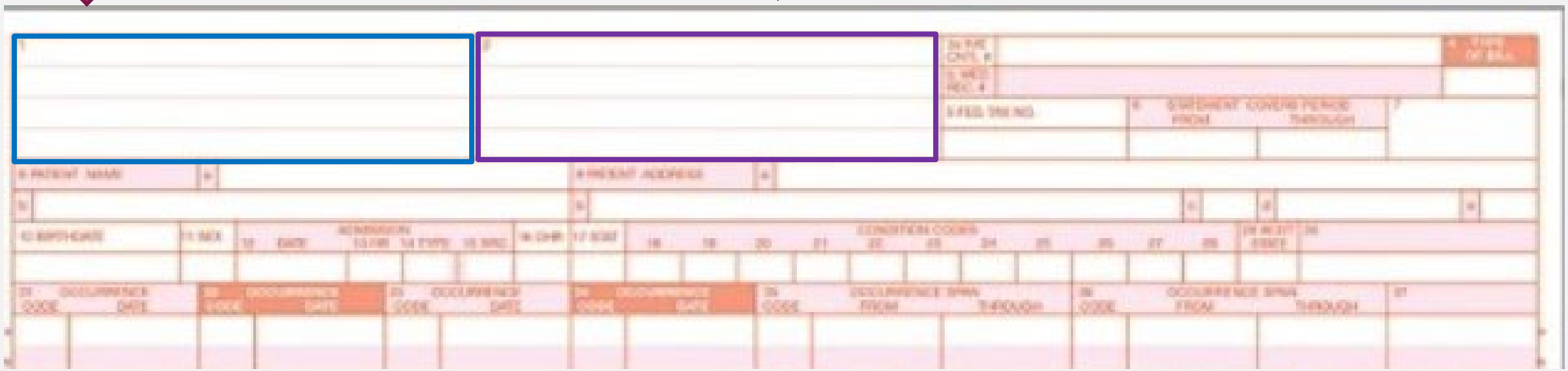
https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/Downloads/5010_8-31-11National_Call_QA.pdf

# UB-04

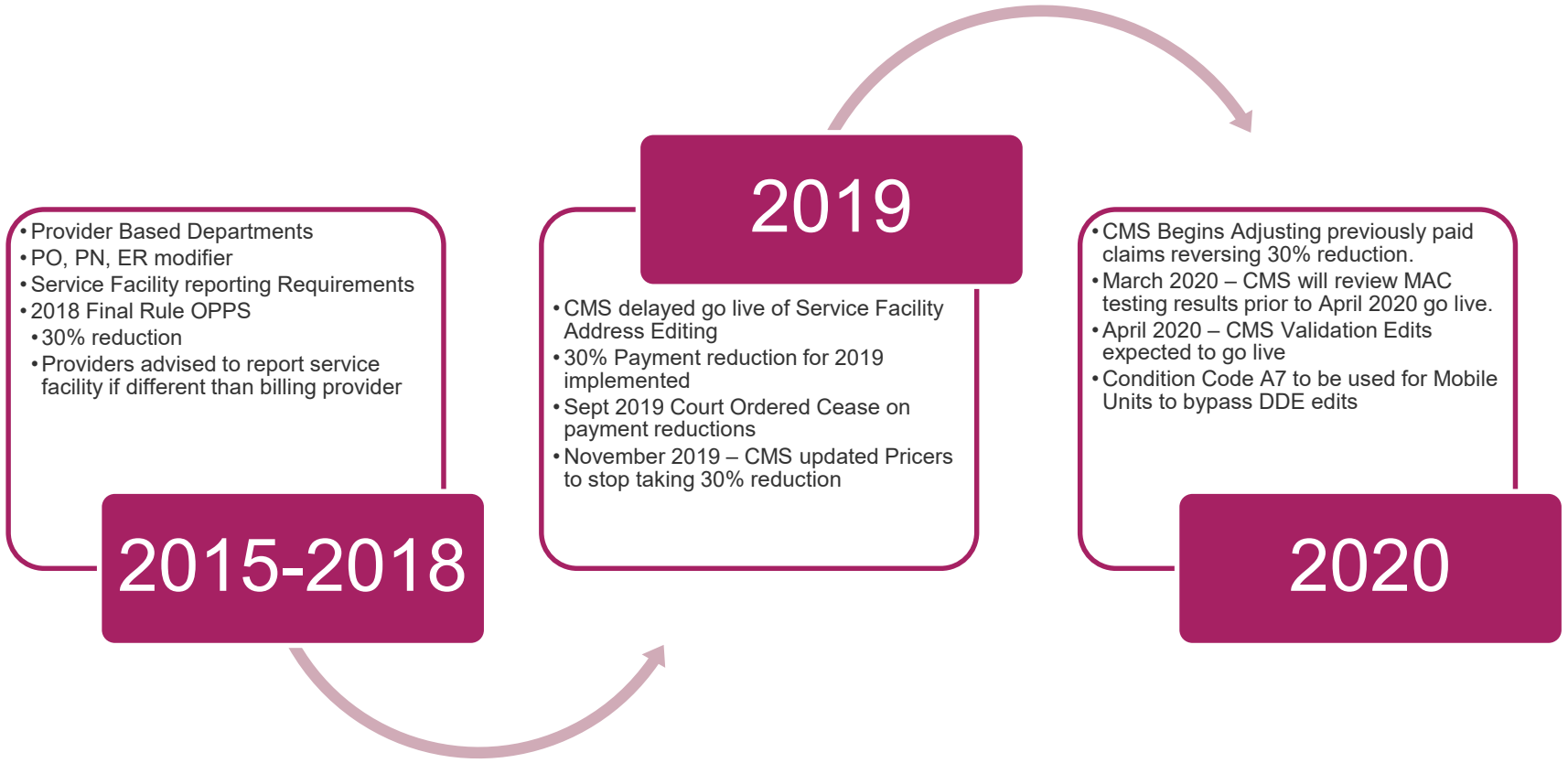
- Form Locater 1 = Billing Provider
- Physical address with 9 digit zip code required

Form Locater 2 = Pay To Provider

P.O. Box/Lock Box Addresses with 9 digit zip code



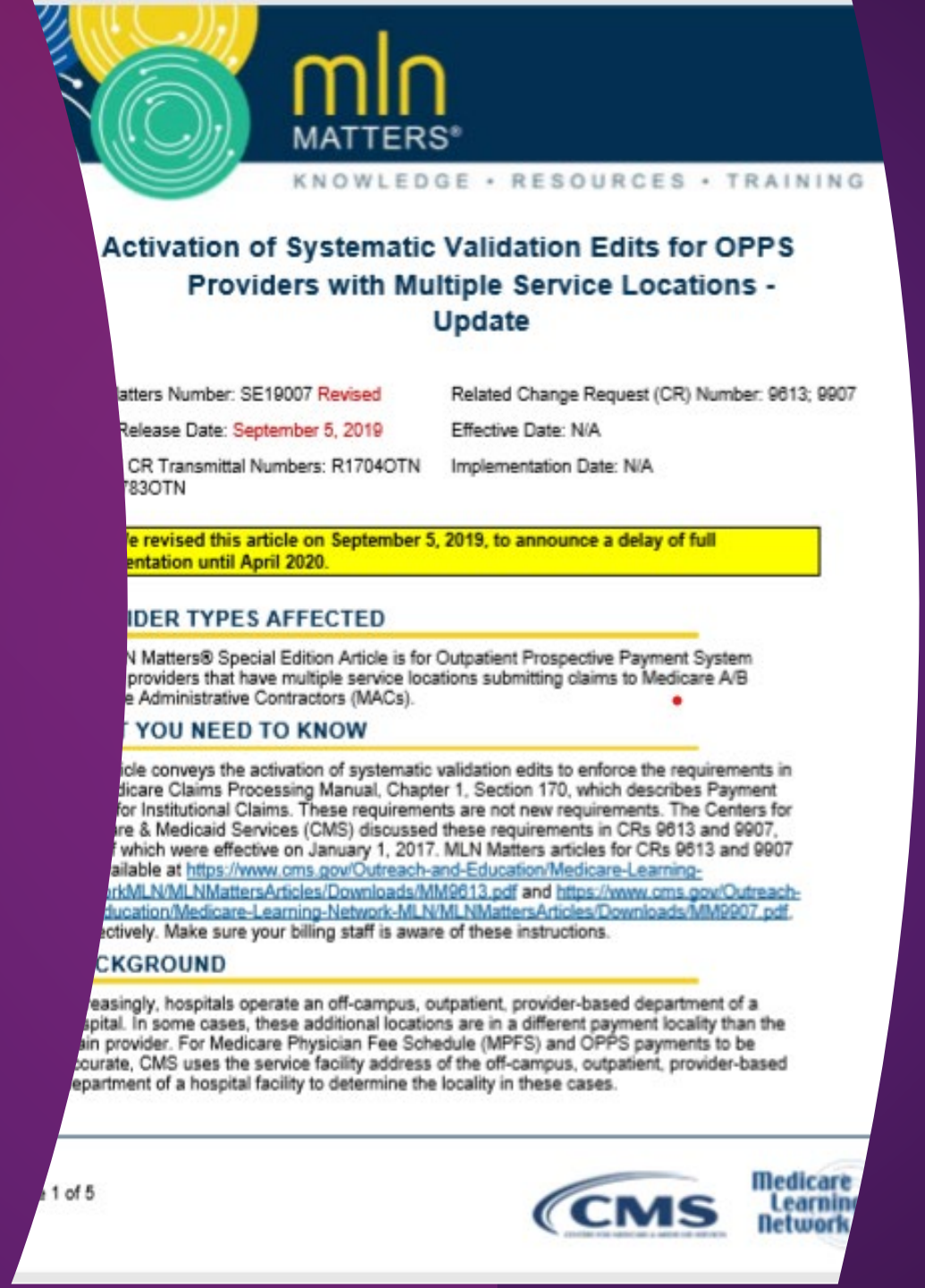
# Timeline for Provider Based Department



# Upcoming CMS Validation Edits

# MLN Matters Number: SE19007

Revised Related Change Request (CR) Number: 9613; 9907
Article Release Date: September 5, 2019



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## Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update

atters Number: SE19007 Revised | Related Change Request (CR) Number: 9613; 9907

Release Date: September 5, 2019 | Effective Date: N/A

CR Transmittal Numbers: R1704OTN 783OTN | Implementation Date: N/A

e revised this article on September 5, 2019, to announce a delay of full entation until April 2020.

IDER TYPES AFFECTED

N Matters® Special Edition Article is for Outpatient Prospective Payment System providers that have multiple service locations submitting claims to Medicare A/B e Administrative Contractors (MACs).

YOU NEED TO KNOW

icle conveys the activation of systematic validation edits to enforce the requirements in dicare Claims Processing Manual, Chapter 1, Section 170, which describes Payment for Institutional Claims. These requirements are not new requirements. The Centers for re & Medicaid Services (CMS) discussed these requirements in CRs 9613 and 9907, which were effective on January 1, 2017. MLN Matters articles for CRs 9613 and 9907 ailable at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-rkMLN/MLNMattersArticles/Downloads/MM9613.pdf and https://www.cms.gov/Outreach-ducation/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf ctively. Make sure your billing staff is aware of these instructions.

CKGROUND

easingly, hospitals operate an off-campus, outpatient, provider-based department of a spital. In some cases, these additional locations are in a different payment locality than the in provider. For Medicare Physician Fee Schedule (MPFS) and OPPS payments to be curate, CMS uses the service facility address of the off-campus, outpatient, provider-based epartment of a hospital facility to determine the locality in these cases.

1 of 5

CMS

Medicare Learning Network

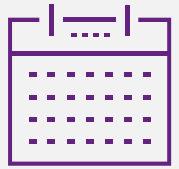
NOTE:

On September 5, 2019, CMS announced another delay of the full implementation until April 2020.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19007.pdf

# Key Dates to Remember

- **CMS implemented required reporting of modifier PO in 2016.**
- **In 2017, CMS expanded the Modifier reporting rule to include PN and ER to distinguish between excepted vs non-excepted PBD's and Free-Standing ER.**



**CMS has been testing since 2018 and has delayed implementation twice:**

**Delayed from July 2019** to October 2019

**Delayed again now from October 2019** to April 2020

# Key Points to Remember

- Affects OPPS providers with Off-Campus Facilities – Provider Based Clinics or Departments, Off Campus Emergency Rooms
- Modifiers should accompany all off-campus services (ER, PO, or PN). The only exceptions to modifier reporting at an off-campus location are services rendered at the patient home, mobile/portable units, or ambulance services claims.
- Service Facility reporting is required if ALL services performed were at an off- campus and none were at Main Campus.
- Main Campus locations may include facilities within 250 feet by definition from a reporting perspective hence modifiers are not required.
- Handling of Mobile Units expects service facilities reported for items paid under MPFS and addresses won't match PECOS. Condition Code A7 will be required to avoid triggering CMS Validation edits.
- Report only Billing Provider Main Campus location alone if there are ANY services performed at Main Campus Location and do not list the service facility.
- If ALL Services were performed at an off-campus location including services exempted from PO or PN normally and Service Facility reporting is needed, then ALL lines including exempted services must have a PO, PN or ER modifier as appropriate.
- CMS expects providers to insure their 855A practice locations are properly enrolled.
- Providers may encounter issues with crossovers if enrollment with subsequent payers differs.
- Providers may encounter issues with secondary payers initially with condition code A7 if payers do not maintain their ANSI standards correctly.

# Key Dates to Remember

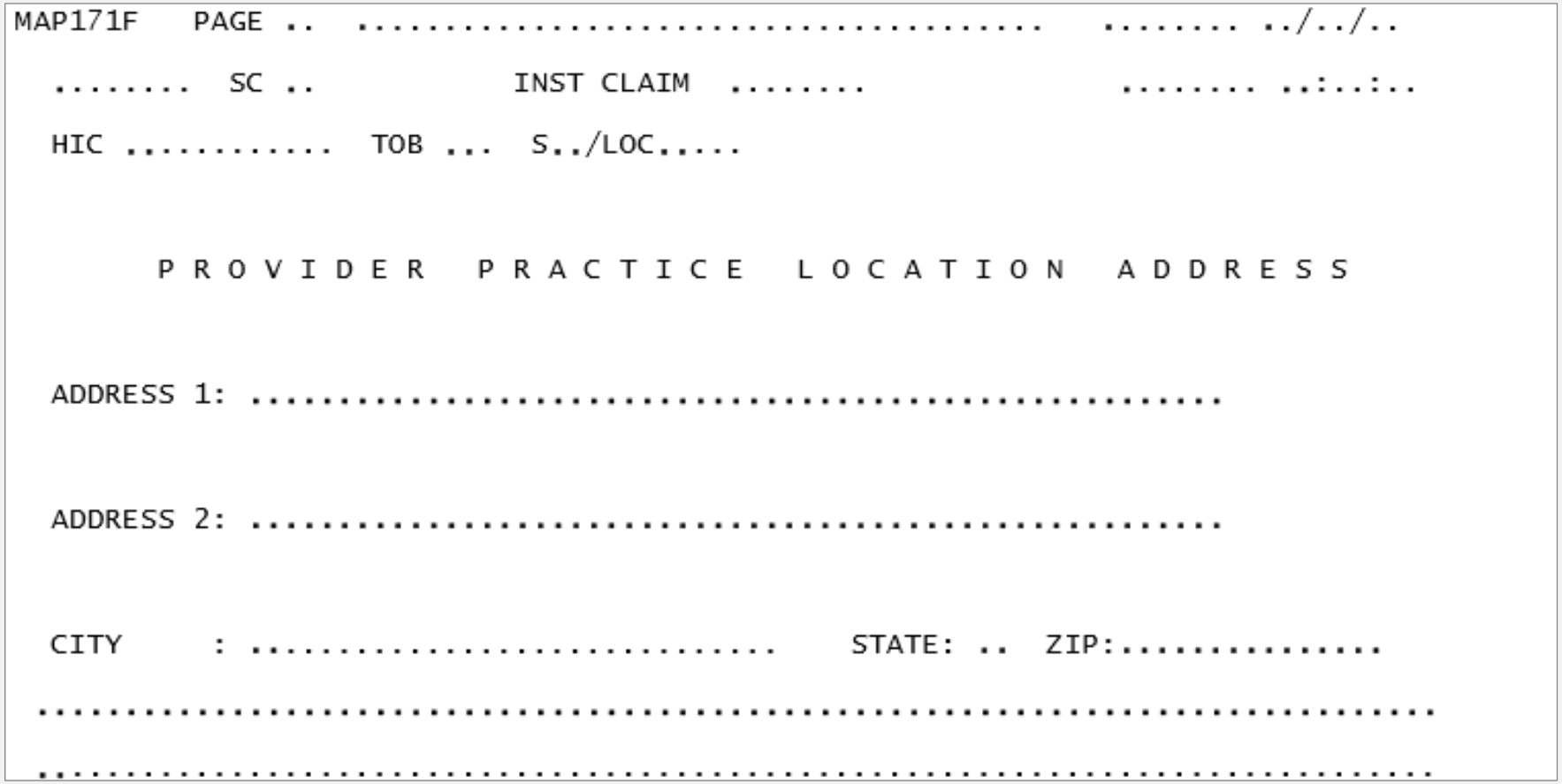
- Service Facility PECOS Screens in DDE in April 2019 – Map 1AB1 and MAP 1AB2
- Map 1AB1 is the listing of all Provider Based locations from PECOS
- MAP 1AB2 is the detailed address by location including address line 1, address line 2, City, state, 9 digit zip code
- nThrive developed the following edits to address new Return to Provider reason codes. Edits are visible in provider test sites and address reason code 34978.
- nThrive is in process evaluating edit development with providers comparing data from MAP1AB2 to reported Service Facility Data to address Reason Code 34977.
- CMS released transmittal regarding service facility billing instructions for mobile units prior to April 2020 implementation. This is a key reason for last delay.
- 4/1/20 FL 18-28: New Condition Code A7 for Hospital Services Provided in a Mobile Facility or with Portable Units SEPTEMBER 25, 2019 CONFERENCE CALL MINUTES - https://www.nubc.org/system/files/media/file/2019/11/UB-04_Change_Implementation_Date_Calendar.pdf

# DDE Service Facility Data Entry Screen MAP171F

CMS added the following screen in DDE MAP 171F

Provider submitted service Facility addresses are present in this MAP 171F location

CMS validation edits will compare the data in 171F to the PECOS data on MAP1AB2



# Service Facility Reporting Fields

## CMS testing results with conflicts are related to the following:

- Spelling variations: PECOS may show the word entered was “Road” as part of their address, but the provider entered “Rd” or “Rd.” as part of their address on the claim submission. Another example, in PECOS the word entered was “STE” as part of their address, but the provider entered “Suite” as part of their address on the claim submission.
- Another commonly seen issue relates to Address Line 1 and Address Line 2 deviations between the claim and PECOS. Pecos may have the entire address 123 W Elm Street, Suite 100 but the claim sent has 123 West Elm St on address line 1 and Ste 100 on address line 2.

**NM1 - SERVICE FACILITY LOCATION NAME – 60 Characters 837I – 25, UB-04**

**N3 - SERVICE FACILITY LOCATION ADDRESS**

**N301 – 55 Characters 837I – 25 Characters on the UB-04**

**N302 – 55 Characters 837I – not on UB-04 paper form**

**N4 - SERVICE FACILITY LOCATION CITY, STATE, ZIP CODE**

**N401 City Name – 30 Characters 837I – 12 Characters on the UB-04**

**N402 State Code – 2 Characters 837I – 2 Characters on the UB-04**

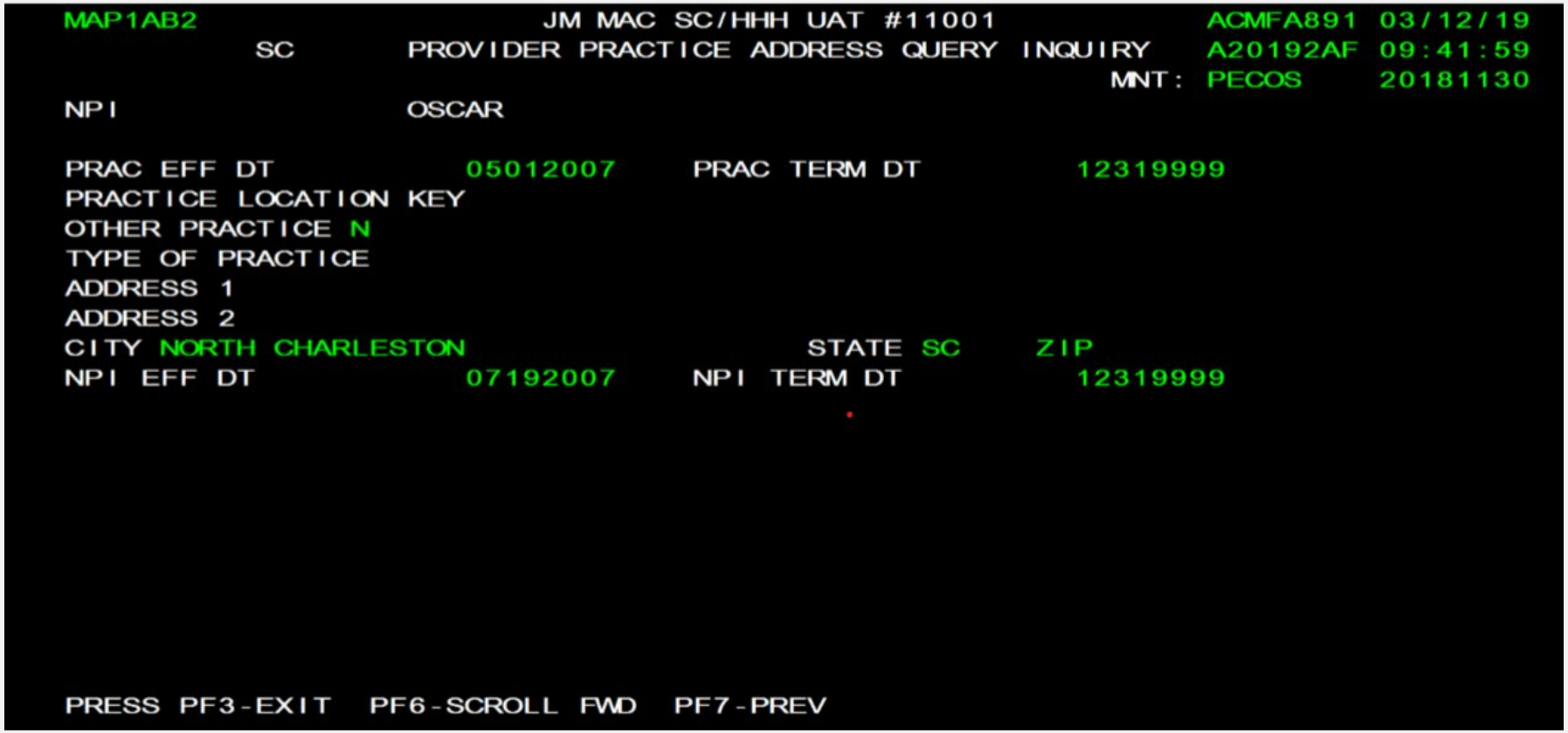
**N403 Postal Code – 15 Characters 837I – 9 Characters on the UB-04**

# DDE Screen Display for PECOS MAP1AB2

CMS validation edits will compare the data in 171F to the PECOS data on MAP1AB2

Note the practice location effective and termination dates and NPI effective and termination dates may also factor into CMS editing.

Return to Provider claims for the new reason codes expected to begin in April. Staff working these RTPs should review this FISS inquiry field to source differences.



# CMS Creates New Return to Provider Reason Codes 34977

## CMS Created New Return to Provider Reason Codes

### Reason Code 34977

**Description:**

- The claim was returned due to one of the following:
- The service facility address submitted on the claim was not identified by the provider as a practice location address when the CMS-855A enrollment form was submitted.
- The service facility address submitted on the claim is not an exact match to the practice location address in PECOS.

**Resolution:**

- To add a new or correct an existing practice location address, submit the CMS-855A enrollment form in PECOS.
- Or, verify the address format in PECOS, DDE, or MAC portal, ensure the service facility address on the claim is an exact match, and resubmit the claim.

**Reference:** CMS MLN Matters article SE19007

## nThrive Edits Solve for New Return To Provider Reason Code

- Institutional Edit(s)#TBD from Medicare Direct Range
- Proposed Edit Text: If location match on MAP1AB1
- “Medicare: The service facility address submitted on the claim %1Address is not an exact match to the practice location address in PECOS %2Address. Please review MAP1AB2.
- Proposed Edit Text: If no location match on MAP1AB1
- “Medicare: The service facility address submitted on the claim does not match any active locations and may not have been identified by the provider as a practice location address when the CMS-855A enrollment form was submitted. Please review DDE MAP1AB1.

# CMS Creates New Return to Provider Reason Codes 34978

## CMS Created New Return to Provider Reason Codes
### Reason Code 34978

**Description**:

- One or more line items on the claim do not contain a PO, PN, or ER modifier.

**Possible Resolution:**

- Report the PO modifier for any services provided at an excepted off-campus provider-based department.
- Report the PN modifier for any services provided at a non-excepted off-campus provider-based department.
- Report the ER modifier for any services provided at an off-campus provider-based emergency department.
- Review claim and remove service facility if services absent modifier were performed at main campus location. However, If all reported services were rendered at an off-campus location, append appropriate modifier for all charge lines including excepted services.

**Reference**: CMS MLN Matters article SE19007

## nThrive Edits Solve for New Return To Provider Reason Code
### Institutional Edit # 25958

- "Medicare: Service Facility is present; however, Modifier PO, PN, or ER is not present on every charge line with a HCPCS. Please review for Modifiers or if Service Facility should be reported. Note that if services without modifiers were performed at the main campus, then the off-campus service facility should not be reported."

- As Per Transmittal 1783 Change Request 9907

| | |
|---|---|
| 9907.1.1 | The Shared System shall review all service lines to ensure that all have a "PO" or "PN" modifier when the service facility address is present. If all lines on the claim do not have a "PO" or "PN" modifier, the modified reason code "34978" shall fire and be set to "RTP". |

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1783OTN.pdf

# CMS Specific Requirements for Service Facility Reporting

# Services rendered on the claim from multiple locations

SCENARIO 1

## No Service Facility Reported if ANY services are rendered at billing provider address

If any services on the claim were rendered at the billing provider address, providers should report the billing provider address only in the billing provider loop 2010AA and do not report the service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).

Scenario 1 Example:

1. Patient presents to off-campus location is seen by provider in clinic.
2. Patient has labs drawn at off-campus draw station.
3. Labs are sent to main campus for testing.

Or

1. Patient presents to off-campus location is seen by provider in clinic.
2. Patient presents to main campus ER or other outpatient diagnostic testing.
3. Services performed at main campus

Then

Clinic charges reported off campus may be billed with appropriate modifier however No Service Facility should be reported as claim contains charges for services performed at Main Campus.

# Services rendered on the claim from multiple locations

SCENARIO 2

## Service Facility is Reported if No Services rendered at Main Billing Provider location

If any services on the claim were rendered at more than one of the campus locations of a multi-campus provider that is not the main billing provider address, providers should report the service facility address in loop 2310E if all of the service facility addresses are different from the billing provider address in loop 2010AA (or in DDE MAP 171F screen for DDE submitters) from the first registered campus encounter of the “From” date on the claim.

Scenario 2 Example:

1. Patient presents to off-campus location is seen by provider in clinic.
2. Patient has labs drawn at off-campus draw station.
3. Labs are performed at off-campus location, i.e. using POC testing like CLIA Waived services.

Or

1. Patient presents to off-campus location is seen by provider in clinic.
2. Patient presents to another off-campus location for other outpatient diagnostic testing.
3. No Services performed at main campus

Then

Clinic charges reported off campus must be billed with appropriate modifier based on each location (PO, PN, or ER). All service lines expected to have an appropriate PO,PN, ER modifier. Provider must report Service Facility typically based on first registered campus.

# Services rendered on the claim from multiple locations

SCENARIO 3

**Service Facility is not required but may be reported if No Services rendered at Main Billing Provider location but located within distance requirement of Main Campus and No off-campus modifier needed for the on-campus services.**

If any services on the claim were rendered at one of the campus locations of a multi-campus provider that is not the main billing provider address and services were also rendered at other off-campus department practice locations, providers may be submitted with the on-campus address where the services were rendered in the service facility location in loop 2310E if the service facility address is different from the billing provider address in loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

Scenario 3 Example:

1. Patient presents to a provider based department location within the 250 feet rule and is seen by provider in clinic first.

2. Patient may or may not present to other off-campus locations

3. No Services performed at main campus

Then

Clinic charges reported off campus must be billed with appropriate modifier based on each location (PO, PN, or ER). All service lines expected to have an appropriate PO,PN, ER modifier if a service facility location is present. However, if first registered location is within 250 feet rule, provider's service facility location reporting may not be required. Provider must report Service Facility typically based on first registered campus.



https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9930.pdf

# Services rendered on the claim from multiple locations

SCENARIO 4

## Service Facility is Reported if No Services rendered at any multi-campus or main billing location

If no services on the claim were rendered at the billing provider address or any campus location of a multi-campus provider, providers should report the service facility address in loop 2310E (or in DDE MAP 171F screen for DDE submitters) from the first registered department practice location encounter of the “From” date on the claim.

Scenario 4 Example:

1. Patient presents to mobile provider based department location.

2. Patient does not present to main campus or any other off-campus locations

3. Service reported is subject to PO, PN modifier reporting.

4. Service location is reported but not related to facility enrollment.

5.Providers may need to append Condition Code A7 to bypass CMS exact match validation edits.

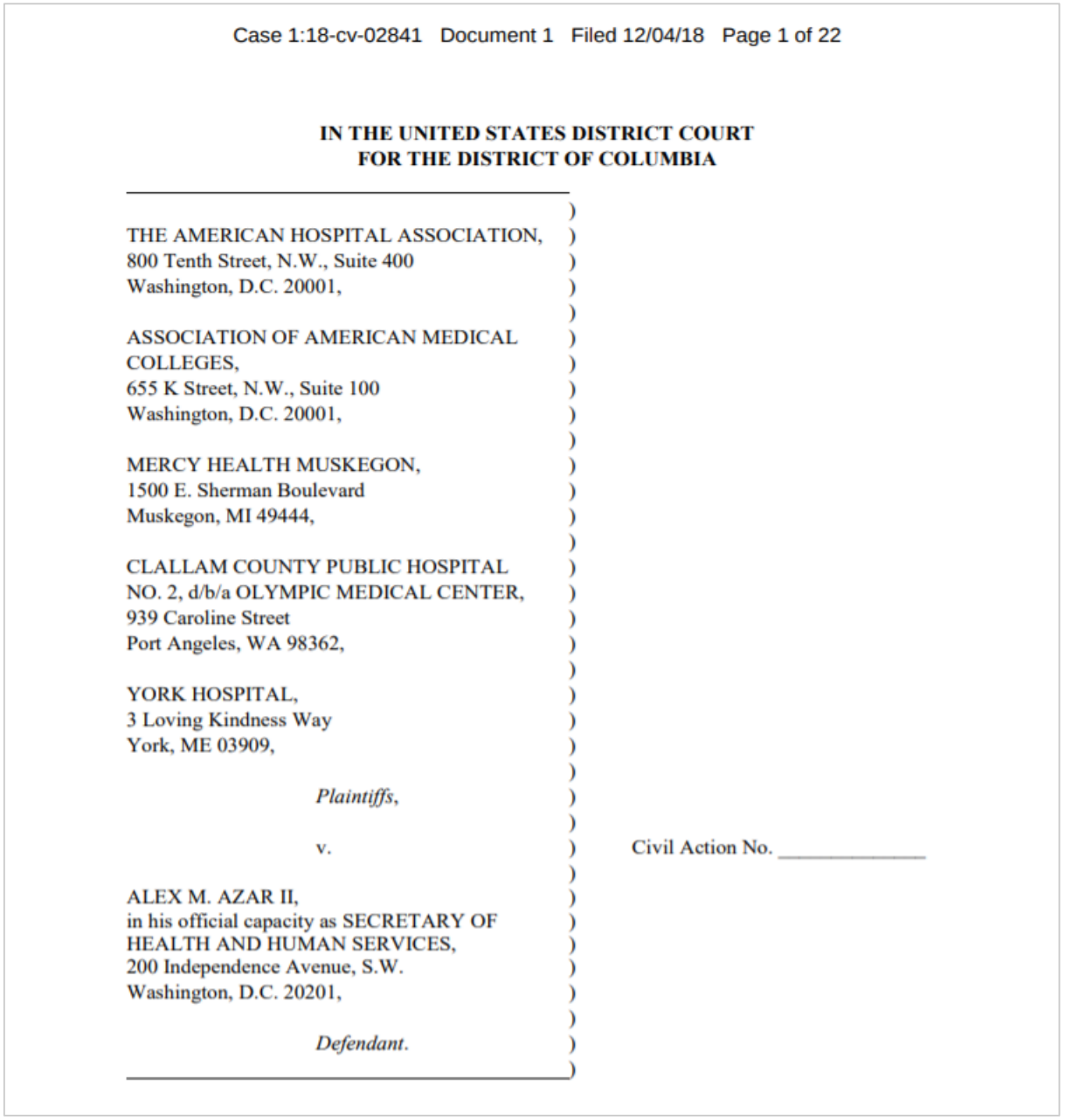
Then

Clinic charges reported off campus must be billed with appropriate modifier based on each location (PO, PN, or ER). All service lines expected to have an appropriate PO,PN, ER modifier if a service facility location is present. However, if location is is not one of the provider’s service facility locations, reporting A7 Condition Code may be required when Service Facility is present but not matching to PECOS.  Provider must report Service Facility typically based on first registered campus.

# Court Decision Impact on Reimbursement and Claims

# AHA, AMA and Providers Sued CMS

https://www.aha.org/system/files/2018-12/complaint-challenging-site-neutral-payment-policy181204.pdf



Case 1:18-cv-02841 Document 1 Filed 12/04/18 Page 1 of 22

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE DISTRICT OF COLUMBIA**

THE AMERICAN HOSPITAL ASSOCIATION,
800 Tenth Street, N.W., Suite 400
Washington, D.C. 20001,

ASSOCIATION OF AMERICAN MEDICAL COLLEGES,
655 K Street, N.W., Suite 100
Washington, D.C. 20001,

MERCY HEALTH MUSKEGON,
1500 E. Sherman Boulevard
Muskegon, MI 49444,

CLALLAM COUNTY PUBLIC HOSPITAL NO. 2, d/b/a OLYMPIC MEDICAL CENTER,
939 Caroline Street
Port Angeles, WA 98362,

YORK HOSPITAL,
3 Loving Kindness Way
York, ME 03909,

*Plaintiffs*,

v.

Civil Action No. _____

ALEX M. AZAR II,
in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES,
200 Independence Avenue, S.W.
Washington, D.C. 20201,

*Defendant*.

# Timeline of Events

- Until 2015, all off-campus provider-based departments were reimbursed under the Outpatient Prospective Payment System (“OPPS”).
- Section 1833(t) of the Social Security Act (the Act), as amended by Section 603 of the Bipartisan Budget Act of 2015, requires that certain off-campus departments of a hospital provider be paid under the “applicable payment system” rather than under the Hospital Outpatient Prospective Payment System.
- CMS established payment policies to pay nonexcepted off-campus departments of a hospital provider under the Medicare Physician Fee Schedule effective for services furnished on or after January 1, 2017. CMS begins to stress the importance of ensuring that an accurate address for each hospital department practice location is included on the CMS 855A enrollment form.
- 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. MPFS is affected by zip code locality hence the importance of service facility reporting.
- The Final Rule in 2018 directed a 30% reduction beginning in 2019.
- The court ruling in September vacated this change in reimbursement as directed by the 2018 OPPS Final Rule stating that “CMS was not authorized to ignore the statutory process for setting payment rates in the Outpatient Prospective Payment System and to lower payments only for certain services performed by certain providers.
- Currently, CMS is retroactively adjusting claims paid in 2019 and repaying provider for the 30% reduction taken which the court indicated was inappropriate.

- The court ruling required CMS to take action to stop taking the reduction.
- In additions, providers will now receive retroactive adjusted payments which will result in open balances for increased coinsurance due from either patient secondary insurance plans, Medicaid payers or patients.
- Communication strategies with patients may be needed to explain open balances.

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PRESS RELEASES | PATIENT CARE | ADVOCACY

## Joint Statement on Outpatient Payment Policy Court Decision from AHA and AAMC

SEPTEMBER 17, 2019

SHARE:

*Below is a joint statement from the AAMC (Association of American Medical Colleges) and the American Hospital Association (AHA):*

**Stuart Heiser, Sr. Media Relations Specialist**
sheiser@aamc.org
202-828-0059

We are pleased with the District Court's decision that the Department of Health and Human Services exceeded its statutory authority when it reduced payments for hospital outpatient services provided in grandfathered off-campus provider-based departments. The ruling, which will allow hospitals to maintain access to important services for patients and communities, affirmed that the cuts directly undercut the clear intent of Congress to protect hospital outpatient departments because of the many real and crucial differences between them and other sites of care. Now that the court has ruled, it is up to the agency to put forth remedies for impacted hospitals and the patients they serve.

Check your Medicare Contractor's website regularly for updates:

See for example Novitas Solutions reference the open production issue:

https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00003625

| | | | | | | |
|---|---|---|---|---|---|---|
| 2/24/20 | Outpatient | Type of Bill (TOB) 13X | NA | Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments .<br><br>The American Hospital Association challenged CMS's use of its authority under Subsection (t)(2)(F) of the Medicare statute to pay for certain outpatient clinic visit services provided at excepted off-campus Provider-Based Departments (PBDs) at the same rate that CMS uses to pay non-excepted off-campus PBDs for those services under the separate Physician Fee Schedule as finalized with Final Rule, Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting, 83 Fed. Reg. 58,818 (Nov. 21, 2018) (Rule).<br><br>The United States District Court for the District of Columbia issued instructions for CMS to immediately cease the clinic visit provided at excepted off-campus PBDs payment reduction for CY 2019 implemented with final Rule, Medicare Program: Changes to Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting, 83 Fed. Reg. 58,818 (Nov. 21, 2018) (Rule). | CMS installed a revised Hospital Outpatient Prospective Payment System Pricer to update the rates being applied to claim lines. The revised Pricer went into production on November 4, 2019, and applies to claims with a line item date of service of January 1, 2019, and after. Over the next few months, Novitas will automatically reprocess claims paid at the reduced rate; no provider action needed. We will update this posting when the adjustments actually begin. | Open |

# Frequently Asked Questions

# Frequently Asked Questions

**If a patient is seen at an off-campus clinic and also goes to off-campus draw station. All labs however are performed at main campus the same day.** In this case, services were performed at main campus. Does this make it such that no off-campus facility should be reported?

**No service facility address should be reported because not all services were furnished or provided in an off-campus location.**

Effective January 1, 2015, the definition of modifier –PO is “Services, procedures, and/or surgeries furnished at excepted off-campus provider-based outpatient departments.” This modifier is to be reported with every HCPCS code for all outpatient hospital items and services furnished in an excepted off-campus provider-based department of a hospital. See 42 CFR 413.65(a)(2) for a definition of “campus”.

Effective January 1, 2017, the definition of modifier “PN” is “Nonexcepted service provided at an off-campus, outpatient, provider - based department of a hospital.” This modifier was established to identify and pay nonexcepted items and services billed by an off-campus department of a provider. Nonexcepted items and services are described in the regulations at 42 CFR 419.48

# Frequently Asked Questions

**If multiple off-campus locations, and one is a PO and the other is PN, the logic directed seems to indicate that you report the first location the patient is seen.** Hence, can a combination of PO and PN exist on the same claim or is never expected?

Yes, a combination of PO and PN can exist on the same claim.

**Should the PO or PN modifier be applied to services provided through Medicare Advantage?**

No, the PO/PN modifier does not apply to services provided through Medicare Advantage. CMS however does not indicate any limitation to Managed Medicare Plans from adopting nor should these payers disallow reporting of valid modifiers.

Providers should note Managed Medicare Plans however do not maintain enrollment via PECOS nor the 855A process hence payment modeling may not be accurate for Part C payers.

**How will CMS handle services provided by Mobile Units with this reporting requirement?**

The newly implemented delay is primarily due to the need to resolve this issue. At this time, CMS is worked with NUBC to request a new condition code as a means to identify mobile units and as such could programmatically be used to avoid triggering Return to Provider for failure to match on address.

NUBC approved the use of A7 condition code to be used for this situation.

# Frequently Asked Questions

**Given the current situation with Covid-19, will we see any guidance from CMS on this for temporary locations set up to address testing or treatment?** In this case, services were performed at a location that is not main campus or associated to my provider locations. Does this make it such that no off-campus facility should be reported?

**CMS is currently entertaining this issue per my CMS contacts. Guidance is expected on this issue as well as information related to the roll out of these validation edits.**

**nThrive has been in contact with CMS and has been told to expect public communication on this matter shortly.**

# References


- CMS Change Request (CR)9231
- CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 20.6.6.11
- CMS IOM, Publication 100-05, Medicare Secondary Payer Manual
- CMS Medicare Learning Network (MLN) Matters (MM) 9613
- CMS MLN Matters Special Edition (SE) 18002
- CMS MM9907
- CMS MM9930
- CMS MM11099
- CMS Program Memorandum A-03-030
- CMS SE18023
- CMS SE19007
- CMS Change Request (CR)11470
- Federal Register Provider-Based Definitions - 42 CFR 413.65 (d) (e)
- https://www.sheppardhealthlaw.com/2019/09/articles/medicare/cms-rule-reimbursement-services-grandfathered-campus/
- https://www.aha.org/system/files/2018-12/complaint-challenging-site-neutral-payment-policy181204.pdf
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019downloads/R2394OTN.pdf