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

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Note: We revised this article on June 28, 2019, to provide an update on Round 3 testing and to announce a delay of full implementation until October 2019.

PROVIDER TYPES AFFECTED

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

WHAT YOU NEED TO KNOW

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

BACKGROUND

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

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Claim Level Information:

Medicare outpatient service providers report the service facility location for an off-campus, outpatient, provider-based department of a hospital in the 2310E loop of the 837 institutional claim transaction. Direct Data Entry (DDE) submitters also must report the service facility location for an off-campus, outpatient, provider-based department of a hospital. Paper submitters report the service facility address information in Form Locator (FL) "01" on the paper claim form. For MPFS services, Medicare systems use this service facility information to determine the applicable payment method or locality whenever it is present.

Additionally, Medicare systems will validate service facility location to ensure services are provided in a Medicare enrolled location. The validation will be exact matching based on the information on the Form CMS-855A submitted by the provider and entered into the Provider Enrollment, Chain and Ownership System (PECOS). Providers need to ensure that the claims data matches their provider enrollment information.

When all the services rendered on the claim are from the billing provider address, providers are:

- To report the billing provider address only in the billing provider loop 2010AA and not to report any service facility location in loop 2310E (or in DDE MAP 171F screen for DDE submitters).

When all the services rendered on the claim are from one campus of a multi-campus provider that reports a billing provider address, providers are:

- To report the 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 loop 2010AA (or in DDE MAP 171F screen for DDE submitters).

When all the services rendered on the claim are from the same off-campus, outpatient, provider-based department of a hospital, providers are:

- To report the off-campus, outpatient, provider-based department service facility address in the service facility provider loop 2310E (or in DDE MAP 171F screen for DDE submitters).

When there are services rendered on the claim from multiple locations:

- 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).
- 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.

- 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 should report the 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).
- 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.

National Testing

Round 1 Testing

During the week of July 23, 2018, through July 30, 2018, CMS performed a national trial activation of the FISS Edits 34977 and 34978 in production environments. Reason Codes 34977 (claim service facility address doesn't match provider practice file address) and 34978 (Off-campus provider claim line that contains a HCPCS must have a PN or PO) were activated. The testing was transparent to providers as most claims impacted by the test were suspended for one (1) billing cycle and then editing was turned off so the claim could continue processing as normal.

This national test brought to light that many providers are not sending the correct exact service facility location on the claim that produces an exact match with the Medicare enrolled location as based on the information entered into the PECOS for their off-campus provider departments.

Most discrepancies had to do with spelling variations. For example, in PECOS 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.

Round 2 Testing

Providers should also ensure that all practice locations are present in PECOS and if any locations are not in PECOS to submit the 855A to add the location(s). Providers can review their practice locations in PECOS and/or the confirmation letter from PECOS when they last enrolled that was received from their A/B MAC to ensure that their service facility address for their off-campus provider department locations provided on claims is an exact match.

CMS conducted a second round of national testing in November 2018. Providers should have used the time before this national testing to correct the off-campus provider department location addresses within their billing systems to match exactly PECOS for their off-campus provider departments.

Round 3 Testing

Prior to conducting round 3 testing, CMS issued instructions to the FISS maintainer to make the practice location address screen available to providers in DDE at the April 2019 system quarterly release. Starting in April 2019, the practice location screen will be available in DDE. CMS has postponed full production implementation for three additional months to allow time for providers to adjust to the new practice location screen. CMS will continue with additional round(s) of testing to ensure that we have a smooth implementation of the edits. CMS plans to conduct a June 2019 national testing to ensure providers have used the new practice location screen tool and made necessary claims submission updates to their systems.

Round 3 Testing Update & Full Production Delayed Another Quarter

CMS has completed round 3 testing. We are in the process of analyzing the data, but at this point we have discovered no major issues during round 3 testing. Based on stake-holder comments and to allow additional time to review the round 3 testing, however, CMS has decided to postpone full production implementation for three additional months until October 2019. Once the October 2019 Quarterly release is implemented, CMS will direct A/B MACs to permanently turn on the edits and set them up to Return-to-Provider (RTP) claims that do not exactly match. Providers can make corrections to their service facility address for a claim submitted in the DDE MAP 171F screen for DDE submitters. **Providers who need to add a new or correct an existing practice location address will still need to submit a new 855A enrollment application in PECOS.**

CMS expects that the 2½ year time frame that the edits have not been active have provided ample time for providers to validate their claims submission system and the PECOS information for their off-campus provider departments are exact matches.

ADDITIONAL INFORMATION

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
June 28, 2019	We revised this article to provide an update on Round 3 testing and to announce a delay of full implementation until October 2019.
March 26, 2019	Initial article released.