Report on Medicare Compliance Volume 32, Number 26. July 24, 2023
Edits That Reject Claims Without Address Match, Correct Location Take Effect Aug. 1

By Nina Youngstrom

CMS on Aug. 1 will turn on validation edits that have been waiting in the wings for seven years, according to a July 11 MLN Matters (SE19007 revised).[1] The edits will reject Medicare claims for services provided at off-campus provider-based departments 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 provider-based departments accurately. That's increasingly a challenge with the growth in their number and distance from the main hospital. CMS is watching the way hospitals report practice locations to distinguish between non-excepted, off-campus provider-based departments, which are paid significantly less for services than excepted, off-campus provider-based departments, said Valerie Rinkle, president of Valorize Consulting. The same goes for off-campus provider-based departments that are dedicated emergency rooms (DEDs).

To make sure Medicare knows which is which, non-excepted locations are required to report services with a PN modifier, while excepted locations use a PO modifier and DEDs an ER modifier. Claims may be kicked if modifiers don't square with the addresses as enrolled. (Off-campus provider-based departments are non-excepted if they opened for business after Nov. 2, 2015.)