moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM064
Policy Title:	**Modifiers PO & PN for G0463 Clinic Visit Services - Medicare Advantage**		
Section:	Modifiers	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☐ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☒ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☐ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Type:	☒ Services furnished in off-campus provider-based department (PBD) of hospital Does not apply to Critical Access Hospitals (CAHs)
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	4/14/2015	Initially Published:	3/13/2019
Last Updated:	5/8/2024	Last Reviewed:	5/8/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?	No		
Last Update Effective Date for Texas:	5/8/2024		

Reimbursement Guidelines

A. Billing Requirements

1. G0463 must be reported with either modifier PN or modifier PO when required by CMS.
   a. Our Medicare Advantage plans follow CMS off-campus Provider-Based Department (PBD) reporting requirements for modifiers PO, PN, and procedure G0463.
   b. The presence of either modifier PN or PO is required to ensure correct pricing is applied to the line item.
   c. Use of the off-campus PBD modifier became mandatory beginning January 1, 2016. (CMS[7])

2. HCPCS modifier PO 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. This applies to G0463 and all other billed procedure codes. (CMS[1])

d. Modifier PO should not be reported for:
    i. Remote locations of a hospital.
    ii. Satellite facilities of a hospital.
    iii. Services furnished in an emergency department.
    iv. Critical Access Hospitals (CAHs).
    v. Services paid under the Physician Fee Schedule (PFS).
    vi. Any facility that does not meet the definition of provider-based.

e. Our Medicare Advantage plans follow CMS reporting requirements for modifier PO.

3. HCPCS modifier PN is to be reported with every HCPCS code for all outpatient hospital items and services furnished in a non-excepted off-campus provider-based department of a hospital. This applies to G0463 and all other billed procedure codes, including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services. (CMS[7])

B. Reimbursement Adjustments

G0463-PO will be reimbursed at an adjusted amount equal to the current CMS adjusted rate of payment, based upon date of service.

1. For 2019 dates of service, this is a 30% reduction to the OPPS fee schedule amount.
2. For 2020 dates of service and following, this is a 60% reduction to the OPPS fee schedule amount.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASO	=	Administrative Services Only
CAH	=	Critical Access Hospital
CCI	=	Correct Coding Initiative (see “NCCI”)
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
HOD	=	Hospital Outpatient Department
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)

Acronym or Abbreviation		Definition
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
NCCI	=	National Correct Coding Initiative (aka "CCI")
PBC	=	Provider-Based Clinic (aka Provider-Based Department)
PBD	=	(aka Provider-Based Clinic)
PBE	=	Provider-Based Entity (aka Provider-Based Clinic, Provider-Based Department)
PFS	=	Physician Fee Schedule
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
UB	=	Uniform Bill

Definition of Terms

Term	Definition
Provider-Based Clinic (PBC), Provider-Based Department (PBD), Provider-Based Entity (PBE)	Department or clinic which is owned and operated by the hospital. The location may be at the main hospital campus or at an off-campus location. The hospital is responsible for financial management, cost reporting, quality assurance, utilization review, oversight, etc. The provider-based clinic must fulfill the obligations of a hospital outpatient department (HOD). (Noridian[5]) Specific physician supervision requirements for diagnostic and therapeutic services must be met and are specified by CMS. Generally, the physician must be in proximity to be "immediately available" if or when needed. A provider-based clinic is a type of hospital outpatient department.
Hospital Outpatient Department	A part of the hospital that treats outpatients. Outpatients are people with health problems who visit the hospital for diagnosis or treatment, but do not at this time need to be admitted to an inpatient bed for overnight care.

Procedure codes (CPT & HCPCS):

Code	Code Description
G0463	Hospital outpatient clinic visit for assessment and management of a patient

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier PN	Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital
Modifier PO	Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"8. Method to Control for Unnecessary Increases in Utilization of Outpatient Services/G0463 with modifier PO

For CY 2019, CMS is finalizing a policy to use its authority under section 1833(t)(2)(F) of the Act to apply an amount equal to the site-specific Physician Fee Schedule (PFS) payment rate for nonexcepted items and services furnished by a nonexcepted off-campus Provider-Based Department (PBD) (the PFS payment rate) for the clinic visit service, as described by HCPCS code G0463, when provided at an off-campus PBD excepted from section 1833(t)(21) of the Act (departments that bill the modifier "PO" on claim lines).

The PFS-equivalent amount paid to nonexcepted off-campus PBDs is 40 percent of OPPS payment (that is, 60 percent less than the OPPS rate) for CY 2019. CMS is phasing this policy in over a two-year period. Specifically, half of the total 60-percent payment reduction, a 30-percent reduction, will apply in CY 2019. In other words, these departments will be paid 70 percent of the OPPS rate (100 percent of the OPPS rate minus the 30-percent payment reduction that applies in CY 2019) for the clinic visit service in CY 2019." (CMS[6])

"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"…… reporting of this modifier is required beginning January 1, 2016." (CMS[1])

Cross References

"Clinic Services In the Hospital Outpatient Setting - Commercial." Moda Health Reimbursement Policy Manual, RPM061.

References & Resources

1. CMS. "Use of HCPCS Modifier – PO." Medicare Claims Processing Manual Pub. 100-04, Chapter 4 - Part B Hospital (Including Inpatient Hospital Part B and OPPS), § 20.6.11.

2. CMS. "Off-Campus Provider Based Department "PO" Modifier Frequently Asked Questions." January 19, 2016; February 12, 2019. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/PO-Modifier-FAQ-1-19-2016.pdf .

3. CMS. "April 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS)." Transmittal 3238. April 22, 2015.

4. CMS. “April 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS).” MLN Matters # MM9097. April 23, 2015.

5. Noridian. “Provider Based Facilities.” Noridian Medicare. November 14, 2018: February 19, 2019. https://med.noridianmedicare.com/web/jea/provider-types/provider-based-facilities .

6. CMS. “January 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS).” MLN Matters # MM11099 Revised. January 17, 2019.

7. CMS. “January 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS).” Transmittal 4204. January 17, 2019.

8. SSA. Social Security Act, Section 1833. December 10, 2016: February 20, 2019. https://www.ssa.gov/OP_Home/ssact/title18/1833.htm .

9. CMS. “Implementing Provider File Updates and PECOS to FISS Interface Via Extract File Updates to Accommodate Section 603 Bipartisan Budget Act of 2015.” MLN Matters # MM9613. January 1, 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9613.pdf .

10. CMS. “Billing Requirements for OPPS Providers with Multiple Service Locations.” MLN Matters # SE18002. January 1, 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18002.pdf .

11. CMS. “Implementing FISS Updates to Accommodate Section 603 Bipartisan Budget Act of 2015 - Phase 2.” MLN Matters # MM9907. January 1, 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9907.pdf .

12. CMS. “January 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS).” MLN Matters # MM9930. January 1, 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9930.pdf .

13. CMS. “January 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS).” MLN Matters # MM11099. January 1, 2019. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11099.pdf .

14. CMS. “Provider-based Status On or After October 1, 2002.” CMS Program Memorandum. Transmittal A-03-030. April 18, 2003. https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/A03030.PDF .

15. CMS. “Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations.” MLN Matters # SE18023. October 12, 2018. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18023.pdf.

16. CMS. “Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Update.” MLN Matters # SE19007 Revised. March 24, 2020. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19007.pdf.

17. CFR. "Federal Register Provider-Based Definitions." 42 CFR 413.65 (d) (e). October 1, 2011. https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol2/pdf/CFR-2011-title42-vol2-sec413-65.pdf.

Background Information

Policy date of origin April 14, 2015. (CMS[3])

The CY 2015 Outpatient Prospective Payment System Final Rule (79 FR 66910-66914) created a HCPCS modifier for hospital claims that is to be reported with every code for outpatient hospital items and services furnished in an off-campus provider-based department (PBD) of a hospital. This 2-digit modifier was be added to the HCPCS annual file as of January 1, 2015, with the label ''PO.'' Reporting of this new modifier was voluntary for CY 2015, with reporting required beginning on January 1, 2016.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
5/8/2024	Formatting Update: Header: Corrected the Type of Business scope to Medicare Advantage only. Annual review. Cross Reference: Hyperlink added.
7/12/2023	Formatting/Update: Annual review. Minor rephrasing; no content changes.

Date	Summary of Update
7/13/2022	Formatting/Update: Change to new header. Acronym Table: 5 entries added. References & Resources: Added entries 9 – 17. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
3/13/2019	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
4/14/2015	Original Effective Date (with or without formal documentation). Policy based on CMS Transmittal 3238. (CMS[3])