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Provider-Based Billing Practices Can Create Medicaid Program Vulnerabilities

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Provider-Based Billing Practices Can Create Medicaid Program Vulnerabilities

Provider-based billing is a specific payment designation created by the Centers for Medicare and Medicaid Services (CMS) that allow a hospital's associate facilities to bill for a facility fee, in addition to professional services rendered. This practice applies to entities that are under the ownership, administrative and financial control of a main provider, as defined by a host of requirements. This designation allows services performed at associated facilities to be billed as an outpatient department, rather than as a freestanding facility, hence the additional facility fee.

Before explaining how this impacts Medicaid programs, it's worthwhile to explore the road paved by provider-based payment methods and billing practices.

In a 2016 report on provider-based policies in the Medicare program, the Office of Inspector General (OIG) estimated that payments for services performed in a provider-based setting were often at least 50 percent higher than payments for the same services rendered in a freestanding facility[i]. These higher payments, which began in 2000, were originally intended to enable higher quality, more coordinated care. The OIG report identified several vulnerabilities for Medicare, although CMS has taken steps to address these issues since the report was published[ii]:

- **Overpayments:** Facilities may improperly bill Medicare and may receive overpayments if they fail to meet all requirements. CMS has no independent method to determine the amount of overpayments were issued when a professional claim does not specify the exact location of each service rendered.
- **Lack of oversight:** Entities voluntarily attest to each designation, and CMS has not determined whether all provider-based facilities meet all requirements.
- **Data-related challenges:** CMS can't identify all provider-based billing in its claims data, making it difficult to separate provider-based billing from other claims, which is needed to ensure appropriate payment levels.
- **Increased costs:** Higher payments have been made using this payment method with no documented benefits for Medicare or its beneficiaries.

In its report, OIG recommended two resolutions, either eliminating the provider-based designation or equalizing physician payment for services regardless of setting[iii]. These recommendations were also supported by the Medicare Payment Advisory Commission (MedPAC)[iv]. Meanwhile, the Bipartisan Budget Act of 2015 already eliminated the higher payments for new off-campus provider-based facilities, but did not eliminate such payments for existing facilities[v].

For its part, CMS has implemented a Medicare Physician Fee Schedule (MPFS) Relativity Adjuster for professional payments based on a percentage of the outpatient prospective payment system (OPPS) rate (40% in calendar years 2018 and 2019). The adjuster means that services are paid 40% of the amount they would have been paid under the OPPS (in outpatient hospital setting), bringing payment levels into alignment for the same services rendered in different settings.

Section 603 of the Bipartisan Budget Act of 2015 directed CMS to no longer pay hospitals the OPPS rate for services furnished in newly designated off-campus provider-based facilities, effective January 1 2017, except under certain circumstances. Locations subject to the exception included emergency departments, off-campus provider-based facilities located within 250 yards of a remote inpatient hospital campus, off-campus provider-based facilities billing services under OPPS on or before November 2, 2015, and on-campus departments located within 250 yards of the main hospital. These circumstances are often referred to as 'excepted'

facilities and services. Starting January 1, 2019, CMS applies site-neutral payments for clinic visits in all off-campus provider-based departments (PBDs), not just non-excepted off-campus PBDs.

As a means to better identify providers utilizing provider-based billing, CMS created unique modifiers and place of service (POS) indicators to be included on either the outpatient UB-04 (facility fee) or professional 1500 claim forms (professional services).

Modifier-PO is used by a hospital to indicate services and procedures provided by off-campus provider-based facilities. While originally created to identify all off-campus provider based practices, its definition was modified in CY 2017 to be used only for excepted services provided by an off-campus provider-based facility.

At the same time, CMS created **Modifier-PN** to be used for non-excepted services provided in the off-campus provider-based facilities. Non-excepted services receive payment from the MPFS rather than from the OPPS.

POS indicator 19 and POS indicator 22 are used for specific identification of professional services performed in the provider-based setting. POS 19 identifies an off-campus provider-based facility while POS 22 identifies a portion of a hospital's main campus. With these POS identifiers, Modifier-PO or -PN should be reported on any institutional (hospital) claim submitted with a corresponding professional claim using POS 19. (Both Modifier-PO and -PN are indicative of services rendered in an off-campus provider-based setting.)

Applying Provider-based Payment Methods to Medicaid

While some of the problems with provider-based billing in Medicare were uncovered and addressed by rule changes, Medicaid programs may be subject to some of the same vulnerabilities.

State Medicaid program administrators must consider the following questions:

- Does the state have a provider-based payment policy?
- Does the state follow Medicare policy?
- Is any such policy reinforced in the Medicaid Management Information System (MMIS)?
- Has any direction been given to providers for use of modifiers or POS indicators?
- Are providers who do not meet requirements billing as provider-based?
- Is there a safeguard to enforce requirements on a prospective or post-payment basis?

The Payment Method Development (PMD) team at Conduent assists state government agencies to determine whether there are any entities billing provider-based services to Medicaid. We can help state administrators determine if such claims follow the state's policies. We can also analyze the financial impact of improper provider-based billing, and provide recommendations for corrective action. Our dedicated team can help resolve your state's specific challenges. Conduent delivers solutions that improve health outcomes, increase administrative and operational efficiencies and lower costs, to help you better serve your patients, payers and providers.

To learn more, please contact Andrew Townsend at Andrew.townsend@conduent.com for more information.

About the Author

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https://insights.conduent.com/government-healthcare/can-provider-based-billing-create-medicaid-vulnerabilities

[1] *U.S. Department of Health and Human Services, Office of Inspector General, CMS is Taking Steps to Improve Oversight of Provider-Based Facilities, but Vulnerabilities Remain, OEI-04-12-00380 (Washington, DC: DHHS, 2005), p. 2.*

[2] *OIG, CMS is Taking Steps to Improve Oversight of Provider-Based Facilities, but Vulnerabilities Remain, p. 11-15*

[3] *OIG, CMS is Taking Steps to Improve Oversight of Provider-Based Facilities, but Vulnerabilities Remain, p. 16-18*

[4] *Medicare Payment Advisory Commission, Report to The Congress, March 2018, p. 54, 60-61.*

[5] *Bipartisan Budget Act of 2015, Sec. 603 (A)(ii)*

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