Reimbursement Policy:

Modifiers PN & PO for Clinic Visit Services (G0463) (Medicare)

POLICY NUMBER	EFFECTIVE DATE:	APPROVED BY
RPC20210011	1/01/2020	**RPC (Reimbursement Policy Committee)**

Reimbursement Guideline Disclaimer: We have policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. We will inform you of new policies or changes in policies through postings to the applicable Reimbursement Policies webpages on emblemhealth.com and connecticare.com. Further, we may announce additions and changes in our provider manual and/or provider newsletters which are available online and emailed to those with a current and accurate email address on file. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in our policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to, legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, and medical or drug policies. Finally, this policy may not be implemented the same way on the different electronic claims processing systems in use due to programming or other constraints; however, we strive to minimize these variations.

We follow coding edits that are based on industry sources, including, but not limited to, CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. We use industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how we handle specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may deny the claim and/or recoup claim payment.

Overview:

EmblemHealth/ConnectiCare have based this reimbursement policy on the guidelines established by the Centers of Medicare and Medicaid Services (CMS) regarding reimbursement of claims for Clinic Visit Services (G0463) submitted with either modifier PO and/or PN appended.

Policy Statement:

This policy applies to hospital claims for clinic visit services (HCPCS Code G0463) provided in an off-campus provider-based department (PBD) of a hospital. This policy does not apply to Critical Access Hospitals (CAHs)

Definitions:

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). 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

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Applicable Codes:

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

Applicable Modifiers:

Modifier	Description
PN	Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital
PO	Excepted service provided at an off-campus, outpatient, provider-based department of a hospital

Reimbursement Guidelines:

EmblemHealth/ConnectiCare follow CMS off-campus provider-based department/clinic reporting requirements for modifier PO and modifier PN and procedure G0463. G0463 must be reported with either modifier PN or modifier PO as required by CMS.

- HCPCS Code G0463 must be billed with either modifier PN or modifier PO appended to ensure that correct pricing is applied
- Do not report both the “PO” and “PN” modifiers on the same claim line. However, if services reported on a particular claim form reflect items and services furnished in both an excepted and a non-excepted hospital off-campus PBD, the “PO” modifier should be used on the excepted claim lines and the “PN” modifier should be used on the non-excepted claim lines.
- HCPCS modifier PO must 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 includes G0463 and all other billed procedures.
- Do not append modifier PO for services in:
    - Remote locations of a hospital.
    - Satellite facilities of a hospital.
    - Services furnished in an emergency department.
    - Critical Access Hospitals (CAHs).
    - Services paid under the Physician Fee Schedule (PFS).
    - Any facility that does not meet the definition of provider-based
- Modifier PN must 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.

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Reimbursement Adjustments:

EmblemHealth/ConnectiCare will apply an adjustment amount equal to the current CMS adjusted rate payment based on date of service.

Dates of Service	Payment Adjustment
2020 going forward	60% reduction to the OPPS fee schedule amount (pays 40%)
2019	30% reduction to the OPPS fee schedule amount

References:

1. CMS. “January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS).” MLN Matters #MM11605. January 6, 2020.
2. 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.
3. 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-ServicePayment/HospitalOutpatientPPS/Downloads/PO-Modifier-FAQ-1-19-2016.pdf .
4. CMS. “April 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS).” Transmittal 3238. April 22, 2015.
5. CMS. “April 2015 Update of the Hospital Outpatient Prospective Payment System (OPPS).” MLN Matters # MM9097. April 23, 2015.
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.

Revision History

Company(ies)	DATE	REVISION
EmblemHealth ConnectiCare	10/2021	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number