Published on *The National Law Review* https://natlawreview.com

Medicare Address Match: Hospital Outpatient Denials Looming

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Beginning in July, 2019, the Centers for Medicare & Medicaid Services (CMS) will direct Medicare Part A/B Macs to perform claim validation edits and return all claims to hospital providers if the address included on their claim forms do not exactly match the information included in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) system. Any discrepancy, such as the difference between the use of “Road” vs “Rd” or “Suite” vs “Ste” on a claim, may mean a return to the provider of claims for services provided in hospital outpatient sites of service. This could result in millions of dollars in claims being returned, and an obvious delay in payment.

The new edits are being implemented to enforce the requirements stemming from the Bipartisan Budget Act of 2015 and resulting CMS “site-neutral” payment policies, which requirements have been memorialized in the Medicare Claims Processing Manual, Chapter 1, Section 170. Non-excepted services provided at an off-campus, outpatient, provider-based department of a hospital are required to be identified as the payment rate for non-excepted items and services billed on an institutional claim are to be paid the Medicare Physician Fee Schedule rate and not the Outpatient Prospective Payment System rate.

The edits have been in process since 2017, and providers were reminded of their application in a March MLN Matters published by CMS. It is expected that they will finally be implemented in July after a final round of testing is completed by CMS in June.

Important Reminder to Hospitals: Action Required

Hospitals still have time prior to the system implementation to educate their billing staff on these changes as well as confirm that their billing information exactly matches PECOS information and correct any inconsistencies. Failure to comply with these changes could result in unpaid claims.

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National Law Review, Volumess IX, Number 156

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