Modifiers PO & PN for G0463 Clinic Visit Services - Medicare Advantage

Last Updated: 5/8/2024 **Last Reviewed: 5/14/2025** **Originally Effective: 4/14/2015**

Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No

If yes, Texas Last Update Effective Date: n/a **Policy #: RPM064**

Scope

Companies: Moda Partners, Inc. and its subsidiaries & affiliates (All) **Provider Contract Status:** Any

Claim Forms: CMS1500 & CMS1450 (paper and electronic versions) **Claim Dates:** Details below

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.[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.[1]
   a. 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.
   b. 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.[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.

Definitions

Acronyms/Abbreviations

Acronym	Definition
CAH	Critical Access Hospital
CMS	Centers for Medicare and Medicaid Services

Acronym	Definition
CPT	Current Procedural Terminology
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HOD	Hospital Outpatient Department
OPPS	Outpatient Prospective Payment System
PBC	Provider-Based Clinic (aka Provider-Based Department, Provider-Based Entity)
PBD	Provider-Based Department (aka Provider-Based Clinic, Provider-Based Entity)
PBE	Provider-Based Entity (aka Provider-Based Clinic, Provider-Based Department)
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)

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). [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 (HOD).
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
PN	Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital
PO	Services, procedures and/or surgeries furnished at off-campus provider-based outpatient departments.

Related Policies

A. "Moda Health Reimbursement Policy Overview." Moda Health Reimbursement Policy Manual, RPM001.
B. "Clinic Services In the Hospital Outpatient Setting - Commercial." Moda Health Reimbursement Policy Manual, RPM061.

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.

Policy History

Reminder: 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 current information by going to: https://www.modahealth.com/medical/policies_reimburse.shtml

Date	Summary of Update
5/14/2025	Acronyms & Related Policies updated. Formatting updates. No policy changes.
5/8/2024	Scope: Corrected the Type of Business to Medicare Advantage only. Formatting updates. No policy changes.
7/12/2023	Minor rephrasing; no policy changes.
7/13/2022	Policy History section added; entries prior to 2022 omitted (in archive storage). Acronyms & Resources updated. Formatting updates. No policy changes.
3/13/2019	Policy document 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. [3]