New Jersey | Medicaid

Reimbursement Policy
Modifiers PN and PO: Off-Campus Provider-Based Hospital Outpatient

Policy Number: **G-26002**
Policy Section: **Coding**
Last Approval Date: **08/12/2026**
Effective Date: **01/01/2027**

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Policy

The health plan allows services rendered in an off-campus provider-based department (PBD) to be reported on the outpatient institutional claim with modifier PN or PO, as applicable, unless provider, state, federal or CMS contracts and/or CMS contracts and/or requirements indicate otherwise.

When HCPCS code G0463 or evaluation and management (E/M) codes 99202–99215 are billed on a UB-04 for services provided in an off-campus PBD and reported with Modifier PN or PO, reimbursement for the outpatient facility claim will be limited to 40% of the allowable amount.

Nonreimbursable

The health plan does not allow modifiers PN and PO in the following circumstances:

- Professional claims billed on a CMS-1500 claim form
- Services are furnished in a licensed, dedicated emergency department and critical access hospital (CAH)
- Services furnished in facilities that do not meet provider-based status requirements, including non-provider-based facilities
- Services furnished in on-campus hospital departments

Related Coding

- **Modifier PN -** Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital
  - Reimbursed at 40% of the allowable
- **Modifier PO -** Excepted service provided at an off-campus, outpatient, provider-based department of a hospital
  - Reimbursed at 40% of the allowable
- **HCPCS G0463 -** Hospital outpatient clinic visits for assessment and management of a patient
  - Reimbursed at 40% of the allowable when a corresponding professional claim is submitted for the same date of service with Place of Service (POS) 19
- **99202-99205 -** Office or other outpatient visit for the evaluation and management of a new patient
  - Reimbursed at 40% of the allowable when a corresponding professional claim is submitted for the same date of service with Place of Service (POS) 19
- **99211-99215 -** Office or other outpatient visit for the evaluation and management of an established patient
  - Reimbursed at 40% of the allowable when a corresponding professional claim is submitted for the same date of service with Place of Service (POS) 19

Definitions

- **Excepted -** A service furnished in an off-campus provider-based department that qualifies for CMS Medicare excepted (grandfathered) payment status based on applicable CMS Medicare requirements
- **Nonexcepted -** A service furnished in an off-campus, outpatient, provider-based department of a hospital that does not qualify for CMS Medicare excepted payment status and is subject to applicable site-neutral payment methodologies.
- **Provider-Based Department -** A department of a hospital that meets CMS Medicare provider-based requirements and bills as part of the hospital under the hospital's CMS Medicare certification.
- **Off-Campus Provider-Based Department -** A provider-based department located more than 250 yards from the main hospital campus or a remote hospital location, as defined by CMS Medicare.
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Modifier Usage

References and Research Materials

This policy has been developed through consideration of the following:

- CMS

- Optum EncoderPro 2026
- State contract
- State Medicaid

Policy History

- **08/12/2026 -** Initial approval 08/12/2026 and effective 01/01/2027

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

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