Manual:	Reimbursement Policy
Policy Title:	**Clinic Services In the Hospital Outpatient Setting**
Section:	Evaluation & Management Services
Subsection:	None

Date of Origin:	8/9/2018	**Policy Number:**	RPM061
Last Updated:	6/4/2021	**Last Reviewed:**	6/9/2021

Scope

This policy applies to all Commercial medical plans for claims with dates of service January 1, 2019 and following.

This policy does not apply to Medicare Advantage plans or Medicaid plans, nor Critical Access Hospitals (CAH).

Reimbursement Guidelines

A. General Policy Statement

For clinic visits and services performed in the hospital outpatient setting, Moda Health does not allow split-billing of Provider-based clinic services as allowed by CMS for its Original Medicare business. This applies whether the clinic is located in an on campus-outpatient hospital setting (POS 22), or an off campus outpatient hospital (POS 19), and whether or not the clinic uses the hospital tax identification number.

Do not split-bill clinic-based services, billing part of the service as a facility charge, and part of the service as a professional charge using POS 19 or 22 or a professional revenue code.

B. Billing Requirements

1. All professional services provided in an outpatient clinic setting are to be billed on a CMS1500 claim form or electronic equivalent, using POS 11 *Office*. Professional claims will be reimbursed according to the applicable professional fee schedule.

2. Revenue Codes 0510 – 0519 Clinic

Clinic charges (revenue codes 0510 – 0519) are facility fee split billing of clinic-based services. This split billing is not allowed, and revenue codes 0510 – 0519 are not reimbursable; charges will deny to facility/provider write-off. Participating providers and facilities may not balance-bill the patient.

3. Revenue Codes 0760 -0769 Specialty Services/Treatment Room

   a. Treatment Room Revenue codes 0760 – 0769 may only be billed when the patient is registered through the hospital business office for Outpatient services on the hospital campus for a specific procedure, which is performed in a treatment room.

   b. Do not bill Evaluation and Management (E/M) codes (CPT 99201 – 99215, and HCPCS code G0463) under revenue codes 0760 – 0769. These procedure codes are not reimbursable under these revenue codes; charges will deny to facility/provider write-off. Participating providers and facilities may not balance-bill the patient.

   c. Other separately reimbursable services provided in a hospital-owned provider based clinic also should not be billed under revenue codes 0760 – 0769.

   d. These services are to be billed on a CMS1500 claim form or electronic equivalent, using POS 11 *Office*.

Codes, Terms, and Definitions

Acronyms Defined

Acronym		Definition
AMA	=	American Medical Association
ASO	=	Administrative Services Only
CAH	=	Critical Access Hospital
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
HCPCS	=	Healthcare Common Procedure Coding System
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
PBC	=	Provider Based Clinic
PBD	=	Provider Based Department
PBE	=	Provider Based Entity
RVU	=	Relative Value Unit

Definition of Terms

Term	Definition
Split Billing	"Services furnished in a provider-based department are generally billed in two or more claims—so-called split billing. A portion of the payment is made for the claim

Term	Definition
	submitted by the hospital for its facility services, and the remainder is made for the claim for professional services provided by the physician or NPP." (Reese[4])
Provider Based Clinic	Provider-based clinics are owned and operated by a hospital facility. The clinics may be on the same campus as the main hospital facility, or located off-campus. A provider-based clinic must fulfill the obligations of a hospital outpatient department. (Noridian[2])

Place of Service code:

Note: Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service. (CMS MM9726[5])

Code	Short Description	Place of Service Code Long Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)

Cross References

"Modifier PO - G0463 Clinic Visit Services at Excepted Off-Campus Provider-Based Outpatient Department - Medicare Advantage." Moda Health Reimbursement Policy Manual, RPM064.

References & Resources

1. CMS. "Place of Service Code Set." Centers for Medicare & Medicaid. August 21, 2018, https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html .

2. Noridian Medicare. "Provider Based Facilities." Noridian Medicare. August 23, 2018, https://med.noridianmedicare.com/web/jea/provider-types/provider-based-facilities .

3. Gooch, Kelly. "7 Things to Know About Provider-based Billing." Becker's Hospital CFO Report. June 13, 2016. August 22, 2018, https://www.beckershospitalreview.com/finance/7-things-to-know-about-provider-based-billing.html .

4. Reese, Gina M., Esq., RN. "Reimbursement for Facility and Professional Services in a Provider-Based Department." *Medicare Insider.* September 8, 2015. August 22, 2018, http://www.hcpro.com/CCP-320428-5091/Reimbursement-for-Facility-and-Professional-Services-in-a-ProviderBased-Department-by-Gina-M-Reese-Esq-RN.html .

5. MLN. "New Place of Service (POS) Code for Telehealth and Distant Site Payment Policy." Medicare Learning Network (MLN) Matters. MM9726. August 12, 2016: January 13, 2017. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9726.pdf .

Background Information

Facility fees, allowed by Medicare since 2000, have become increasingly common as more physician practices are sold to hospitals. Under the Medicare provider-based billing model, when a patient sees a physician who works in an office building that is owned by the hospital, the hospital can charge the patient a facility fee for the use of the building in which the patient was seen. The facility fee charge is separate from the fee for the physician's professional services. However, if the patient sees a physician at a clinic building owned by a physician group, clinic practice, or an independently owned physician office (e.g. sole-proprietor office), then a separate facility fee may not be charged to the patient in addition to the physician charges.

Patients increasingly want to understand the charges associated with their care, and how these impact their financial responsibilities of deductibles, copayments, and coinsurance. As a result, patients have questions and concerns about these facility fee charges for physician visits, particularly when a clinic building was owned by a physician or clinic group and is subsequently bought by a hospital. Moda Health has developed this policy in response to member complaints and concerns.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document Moda Health's payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between the Moda Health Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives to minimize these variations.

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