Priority Health	BILLING POLICY No. 025
PROVIDER-BASED BILLING	
Effective date: June 1, 2024 **Date of origin: Mar. 2024**	**Review dates: 5/2024, 6/2024, 2/2025, 6/2025, 10/2025, 3/2026, 07/2026, 09/2026**

DEFINITION

This policy defines Priority Health guidelines associated with provider-based billing.

Provider-based billing is a billing process for services rendered in an outpatient department of the hospital, including off campus facilities. The hospital facility may be called an outpatient center, hospital outpatient department, doctor's office, or practice. A provider-based facility must meet certain criteria to attain these Centers of Medicare and Medicaid Services (CMS) designation. Typically, two bills will be sent: a professional claim and a facility claim. This CMS methodology allows facilities to report a claim for costs such as overhead, facility costs, staffing and technical resources, and the professional claims for physician services. Priority Health recognizes provider-based billing. However, we don't separately reimburse facility services for commercial plans.

POLICY SPECIFIC INFORMATION

Commercial plans

Priority Health won't separately reimburse a clinic fee, office visit, or any other facility fee associated with space used to provide Evaluation and Management (E/M), procedures and services in the event they're billed on a UB-04 claim form ('facility fee') regardless of the office being located on the hospital campus and/or using the hospital tax identification number. All services performed during this patient encounter should be reported on the professional claim. Reimbursement made for provider-based services are all-inclusive for practice expenses including overhead, facility, and other related services and expenses. Below are a few examples.

- Routine supply items generally on hand and available to any member are considered incidental and are inclusive of the E/M, procedures, and services performed at visit. This includes medical and surgical supplies, commonly packaged drugs, biologicals, and radiopharmaceuticals,
- Facility charges for treatment rooms or specialty services are not separately payable when performed in association with the professional services reported for provider-based visits.

Provider organizations are responsible for determining the most appropriate way to bill for professional services in their practice setting. The provider organization must determine if the appropriate practice setting rules or guidelines are met for commercial plans when selecting the place of service (POS). Reimbursement of professional services is impacted by the place of service reported, which is derived from either a facility or non-facility rate.

- **Non-facility rates** are comprised of costs associated with physician practice expenses such as overhead, facility costs, staffing and supplies
- **Facility rates** don't include practice expenses.

Applicable POS codes include:

POS code	Reimbursement
11 – Office	Services reported with POS 11 are reimbursed at **Physician Fee Schedule (PFS) non-facility rates**, which

	include practice expense reimbursement at PFS non-facility rates.
19 – Off-Campus-Outpatient Hospital	Services reported with POS 19 and 22 are reimbursed at **PFS facility rates** which don't include practice expense reimbursement at PFS non-facility rates.
22 – On-Campus-Outpatient Hospital	

The following are conditions under which claims will be denied:

- Type of bill: 013X
- Revenue codes associated with services performed in the provider-based hospital department including drugs, clinic charges, treatment rooms, and supplies performed during the visit.
    - Revenue codes 0250-0254;0256-0259
    - Revenue codes 0270-0274;0279
    - Revenue codes 0510-0519
    - Revenue codes 0760-0761
    - Revenue codes 0924-0929
    - Revenue codes 0940-0942, 0949
    - Revenue codes 096x, 097x, 098x
- *Please note that this is not an all-inclusive list.*
  Examples include but aren't limited to E/M, procedures and services performed during visits performed in the provider-based setting.

Services originating in other outpatient hospital departments, such as radiology or pathology, may be reported separately when appropriate.

Medicare and Medicaid

Medicare
We follow traditional Medicare guidelines for billing and reimbursement of provider-based billing as outlined in the CMS Claims Processing Manual and MLN Matters.

As detailed by CMS:
CMS created a HCPCS modifier for hospital claims that's to be reported with each claim line with a HCPCS for outpatient hospital items and services furnished in an off-campus provider-based department (PBD) of a hospital. The "PO" modifier was updated in 2017 for excepted off-campus PBDs. Excepted off-campus PBDs of a hospital must continue to report existing modifier "PO" (Services, procedures and/or surgeries provided at off-campus PBDs) for all excepted items and services with a HCPCS furnished.

CMS established a modifier "PN" (Non-excepted service provided at an off-campus, outpatient, PBD of a hospital) to identify and pay non-excepted items and services billed on an institutional claim.

PO and PN modifiers will trigger rate reductions as outlined by CMS and MDHHS.

Inaccurate claims data that may generate denials:

- Claim service facility address doesn't match provider practice file address
- Off-campus provider claim lines that contain a HCPCS must have a PN or PO
- Modifier PO isn't present on the claim, and an off-campus practice location is reported. Refer to CMS SE18002.
- Modifier PN isn't present on the claim, and an off-campus practice location is reported that has a practice effective date on/after 11/2/15. Refer to CMS SE18002.

Corresponding professional claims should be reported with the appropriate place of service defined for off-campus PBD (19). Failure to accurately bill the appropriate POS for these services will result in a professional claim denial.

Medicaid
MDHHS aligns as closely as possible with Medicare's billing and reimbursement guidelines for billing Hospital Clinic services rendered in a clinic setting (that is part of the licensed, Medicaid enrolled hospital) and that satisfy Medicare requirements for provider-based status. Clinic services rendered in the outpatient hospital include non-emergency outpatient services provided to ambulatory beneficiaries.

MedicaidProviderManual.pdf (state.mi.us) (Clinic Services section)

- MDHHS follows the same protocol for PO and PN modifiers determination as established by CMS. Claim lines with the PN and PO modifiers will result in a payment reduction applied to the OPPS rate.

Service location reporting
As a reminder, the service facility location for off-campus, outpatient PBDs should be reported on the facility claim. Inaccurate provider data will result in a claim denial.

- Service location reporting, including use of the off-campus address in loop 2310E of the 837, is expected consistent with CMS instructions in SE18002

Provider-based billing modifiers

- **PO**: Excepted service provided at an off-campus, outpatient, provider-based department of a hospital
- **PN**: Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital
- **CG:** Policy criteria applied. Facilities should report this modifier when the PBD is "on the campus," or within 250 yards of the hospital or a remote location of the hospital (as defined under 42 CFR 413.65)

Related Policies

- Incidental services and supplies - 013

REFERENCES

- SE18002 SE18002 (cms.gov)
- MM13488 - Hospital Outpatient Prospective Payment System: January 2024 Update (cms.gov)
- MM13568 - Hospital Outpatient Prospective Payment System: April 2024 Update (cms.gov)
- Michigan Department of Health & Human Services (MDHHS) Outpatient ProSPECTIVE PAYMENT System (OPPS) and Ambulatory SurGical Center (ASC) 1st Quarter (January 1, 2019) Update Information
- Michigan Department of Health & Human Services (MDHHS) Important Outpatient ProSPECTIVE PAYMENT System (OPPS) 3RD Quarter (July 1 – September 30, 2016) Update Information

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current

Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Update made
May 30, 2024	Removed definition of Excepted provider-based departments (PBD) and Non-excepted PBDs
June 20, 2024	This policy now only applies to commercial products. We follow traditional Medicare guidelines for billing and reimbursement of provider-based billing as outlined by CMS. For Medicaid, we follow MDHHS guidelines which align as closely as possible with Medicare's guidelines.
Feb. 13, 2025	Added "Disclaimer" section
June 4, 2025	No changes made
October 13, 2025	Added modifier CG
Aug 2026	Effective Nov 16, 2026 Addition of the following information: • Routine supplies and commonly packaged drugs/biologicals utilized during a provider-based visit are inclusive to professional charges – these should not be reported on a separate facility claim. • Clarified that treatment rooms or specialty services are inclusive to professional charges for provider-based visit

	• Detailed specific revenue codes that would no longer be payable on facility when utilized in conjunction with clinic/provider-based visit services
09/17/2026	Moved Provider-based billing modifiers section under Commercial, Medicare & Medicaid policy specific information sections