Provider-based billing

Applies to
All commercial and Medicaid in-network and out-of-network providers and facilities (excluding RHC and FQHC) regardless of reimbursement methodology

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, doctor's office or practice. A provider-based facility must meet certain criteria to attain this 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 some of the facility services for Medicaid and commercial plans.

There are two types of provider-based entities:

Excepted provider-based departments (PBD) include:

- On-campus PBDs
- "Grandfathered" off-campus PBDs – those furnishing and billing for services before Nov. 2, 2015
- Services furnished by a dedicated emergency department.

Non-excepted PBDs include:

- Off-campus departments that don't meet the above exceptions.

Commercial plans and Medicaid
Effective June 1, 2024, Priority Health won't separately reimburse a clinic fee 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.

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 and Medicaid plans when selecting the place of service (POS). Reimbursement of professional services are impacted by 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**: 0510-0519
  Examples include but aren't limited to E/M, procedures and services performed during clinic visit

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

*We align to CMS MA Plans guidelines for modifier use.