moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM061
Policy Title:	Clinic Services In the Hospital Outpatient Setting		
Section:	Facility-Specific	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☐ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☒ Moda Health Plan ☒ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☐ All Types ☒ Commercial Group ☒ Commercial Individual ☒ Commercial Marketplace/Exchange ☒ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☒ Short Term ☐ Other: _____
States:	☐ All States ☒ Alaska ☒ Idaho ☒ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☐ All dates ☒ Specific date(s): January 1,2019 and following ☒ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☒ Facility discharge ☐ Date of processing
Provider Type:	Does not apply to Hospitals paid on an OPPS-based fee schedule, or Critical Access Hospitals (CAH).
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	8/9/2018	Initially Published:	9/20/2018
Last Updated:	11/7/2022	Last Reviewed:	11/8/2023

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

Last Update Effective Date for Texas: n/a	[Last Updated Effective Date for

Reimbursement Guidelines

A. General Policy Statement

For clinic visits and services performed in the hospital outpatient setting, we do 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. When split billing occurs, the professional component of the service(s) is billed on a CMS-1500 or electronic equivalent using POS 19 or 22. This type of split billing is not allowed.

a. Charges submitted under revenue codes 0510 – 0519 are not reimbursable and will deny to facility/provider write-off. Participating providers and facilities may not balance-bill the patient.

b. We require the clinic visit services to only be submitted on a CMS1500 claim form or electronic equivalent, using POS 11 *Office*. This ensures both components of the service are appropriately reimbursed without increased costs to the member or the group. The facility fee portion of the provider-based clinic visit is reimbursed under the practice-expense portion of the RVU for the professional E/M visit procedure code.

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

a. Revenue codes 0760 Specialty Services, General and 0762 Observation Hours may only be billed when the patient is registered through the hospital business office for Outpatient services on the hospital campus for Observation Services (G0378, G0379). E/M codes are not appropriate for Observation service.

b. Revenue code 0761 Treatment Room 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 (e.g., endoscopies, apheresis, pheresis).

I. Do not bill Evaluation and Management (E/M) codes (CPT 99201 – 99215) under revenue code 0761. 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.

II. If a treatment/procedure is performed in the treatment room and billed under revenue code 0761 and a separately identifiable E/M service and submitted with modifier 25 the E/M service will be denied upon initial adjudication; a written appeal with an explanation and medical records may be submitted for a case-by-case individual consideration review.

c. Revenue code 0769 is an unlisted revenue code which we do not accept. (Moda[B])

d. Services provided in a hospital-owned provider-based clinic also shall not be billed under revenue codes 076X; this includes both E/M services and other separately reimbursable

services. See instructions above for billing professional services and E/M services provided in an outpatient clinic setting.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
ASO	=	Administrative Services Only
CAH	=	Critical Access Hospital
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
MPFSDB	=	(National) Medicare Physician Fee Schedule Database (aka RVU file)
NCCI	=	National Correct Coding Initiative (aka "CCI")
PBC	=	Provider Based Clinic
PBD	=	Provider Based Department
PBE	=	Provider Based Entity
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

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 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])

Term	Definition
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[3])

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)

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Effective January 1, 2015, the definition of modifier -PO is 'Services, procedures, and/or surgeries furnished at excepted off-campus provider-based outpatient departments.' This modifier 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. See 42 CFR 413.65(a)(2) for a definition of 'campus'. … reporting of this modifier is required beginning January 1, 2016. We note that beginning in CY 2019 we are finalizing a policy to pay for clinic visits (G0463) billed at excepted off-campus provider based departments (departments that bill modifier 'PO' on their claim lines) at the PFS-equivalent amount. … In other words, these departments will be paid 70 percent of the OPPS rate (100 percent of the OPPS rate

minus the 30-percent payment reduction that applies in CY 2019) for the clinic visit service in CY 2019." (CMS[7])

"A. General
Effective January 1, 2017, the definition of modifier 'PN' is 'Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital.' This modifier was established to identify and pay nonexcepted items and services billed by an off-campus department of a provider.

B. Effect on Payment
Payment for nonexcepted items and services furnished at nonexcepted off-campus provider-based departments reported with modifier "PN" will result in a payment rate under the PFS effective January 1, 2017. The PN modifier is required to be reported on each claim line with each nonexcepted item and service including those for which payment will not be adjusted, such as separately payable drugs, clinical laboratory tests, and therapy services. Nonexcepted items and services are described in the regulations at 42 CFR 419.48." (CMS[8])

"Excepted" off-campus provider-based departments are:

- Those departments operating and billing as off-campus provider-based departments before 11/02/2015.
- Those off-campus provider-based departments under development but not yet billing but which submitted a voluntary provider-based attestation prior to 12/02/2015 are grandfathered in.
- Those off-campus provider-based departments who submitted a mid-build attestation in the first quarter of 2017 are also grandfathered in. (Corley[9])

"Non-excepted" off-campus provider-based departments are those which began operating and billing on or after 11/02/2015 and did not submit the voluntary provider-based attestation or the mid-build attestation by the deadlines listed above. (Corley[9])

Cross References

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

B. "Revenue Codes Ending in "9" ("Other" Categories)." Moda Health Reimbursement Policy Manual, RPM042.

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. "Billing Requirements for OPPS Providers with Multiple Service Locations." Medicare Learning Network. SE18002. Effective January 1, 2017. Last accessed September 20, 2022. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE18002.pdf .

6. MLN. "January 2017 Update of the Hospital Outpatient Prospective Payment System (OPPS)." Medicare Learning Network. MM9930. Effective January 1, 2017. Last accessed September 22, 2022. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9930.pdf .

7. CMS. "Use of HCPCS Modifier – PO." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS), § 20.6.11.

8. CMS. "Use of HCPCS Modifier – PN." *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS), § 20.6.12.

9. Corley, Linda J., MBA, ACPAR, CRCR, CPC. "Provider-Based Billing . . . It Really Is Rocket Science!" Xtend Healthcare. 2019. Last accessed: November 1, 2022. https://www.hfma.org/content/dam/hfma/chapters-websites/region-10/documents/MT%20HFMA-Provider%20Based%20BillingXtend.pdf.

Background Information

Facility fees, allowed by Medicare since 2000, have become increasingly common as more physician practices are sold to hospitals and/or hospitals develop their own provider-based clinics and departments to serve the needs of their patients and community. Under the Medicare provider-based billing model, when a patient sees a physician who works in an office building or clinic 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; the reimbursement for the office visit or procedure code(s) includes a practice expense allowance to cover the cost of the facility and its operations.

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. We have developed this policy in response to member complaints and concerns.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our 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. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. 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 our 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 our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive 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 *****

Policy History

Date	Summary of Update
11/8/2023	Clarification/Update: Header: States changed from "All" to Oregon, Alaska, & Idaho. Changed Texas effective date to n/a. Section B: Clarified what split billing looks like (not accepted) and how clinic services should be billed. Added more details about individual revenue codes 0760 – 0769, and what services are appropriate under each. Further clarification about denials of inappropriate billing. Cross References: Added one entry.
11/9/2022	Formatting & clarification/Update: Change to new header; includes Idaho. Acronym Table: 6 entries added. Coding Guidelines & Sources: 4 entries added. Cross References: Hyperlink added. References & Resources: 5 added, 1 removed. Background Information: Minor rewording and additions. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
9/20/2018	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
8/9/2018	Original Effective Date (with or without formal documentation). Policy based on an Administrative decision by agreement between the Vice President of Claims & Customer Service and the Provider Contracting management.