



BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Corporate Payment Policy 11

PROVIDER BASED BILLING

Updated Effective January 1, 2021

Document Precedence

The Blue Cross and Blue Shield of Vermont (BCBSVT) Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member contracts and employer benefit documents, provider contracts, BCBSVT corporate medical policies, and BCBSVT's claim editing logic. Document precedence is as follows:

- 1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
- 2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
- 3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
- 4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and BCBSVT's claim editing solution, BCBSVT's claim editing solution takes precedence.

Payment Policy

Description

A health care delivery system or hospital may treat a subordinate facility for Medicare purposes either as part of the hospital (referred to as "provider-based") or as freestanding. There are three types of provider-based facilities/organizations: (1) department of a provider – generally referred to as hospital outpatient departments (or "hospital outpatient clinics"); (2) provider-based entity – for example a rural health clinic, skilled nursing facility or home health agency; and (3) remote location of a hospital that furnishes inpatient services under a hospital's certification and CMS Certification number. A provider-based facility that meets specific Medicare regulations submits to Medicare one bill for the professional service and another bill for the hospital/facility resources and services (also referred to as the technical or overhead component). This practice of billing for professional services separately and in addition to technical/building/facility/overhead is called provider-based billing.

Policy

BCBSVT does not allow for provider-based billing (i.e., billing a separate and additional "facility charge" in connection with clinic/office visit services performed by a physician or other medical professional). BCBSVT does not permit provider-based billing for office visits because when BCBSVT develops fees for professional services, due consideration is given to the intensity and resources associated with the services rendered by providers in the office setting. BCBSVT's fees for office-based services are considered all-inclusive and thus are meant to reimburse for the provider and facility/building/technical/overhead portion of the service. In addition, provider-based billing may result in a member paying additional co-payment, deductible, or coinsurance for the clinic service, depending on the member's benefit plan.



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BCBSVT reimburses professional providers for covered services provided in a facility clinic (hospital outpatient) setting when reported on a professional CMS-1500 form with a place of service office. BCBSVT will not separately reimburse a facility for facility clinic (hospital outpatient) visits and services billed, subject to the exceptions listed immediately below. The facility may not seek reimbursement for any technical/building/facility/overhead component of the clinic charge from BCBSVT or the member.

Exceptions where this policy does not apply:

1. This policy does not apply in situations where BCBSVT pays secondary to Medicare (so as to comply with Medicare guidelines).
2. This policy does not apply in situations involving coordination of benefits issues with Medicaid (so as to follow Medicaid guidelines).
3. This policy does not apply to claims submitted by a Veterans' Administration health care entity that is designated as provider-based.
4. This policy does not apply for procedures that are a combination of a physician or other qualified care professional codes with a CMS PC/TC Indicator 1 with their percentage splits. These codes have both a professional component and a technical component. Modifiers -26 and -TC may be used with these codes.
5. This policy does not apply with respect to facility resources for emergency department (ED) visits using CPT evaluation and management (E/M) codes.

Not Eligible for Payment

Subject to the exceptions listed above, the following codes are not eligible for payment and will be denied as provider liability:

- G0463 (hospital outpatient clinic visit for assessment and management of a patient)
- G0466 (FQHC visit, new patient)
- G0467 (FQHC visit, established patient)
- G0468 (FQHC visit, IPPE or QWV)
- G0469 (FQHC visit, mental health, new patient)
- G0470 (FQHC visit, mental health, established patient)

Subject to the exceptions listed above, and except when billed by a Rural Health Center or any other facility required to bill all services on a UB-04 form, clinic/office visit services (including Evaluation and Management CPT® codes in the ranges 99201-99215 and 99241-99245, as well as General Ophthalmological Services CPT® codes in the range 92002-92014) are not eligible for payment when billed on a UB-04 form (with all revenue codes).

Benefit Determination Guidance

Payment for covered services is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible covered services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.



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Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area.¹ A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at <http://www.bcbsvt.com/provider-home> for the latest news and communications.

Eligible Providers

This policy applies to all hospital-affiliated providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

Audit Information:

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

¹ For purposes of this policy, Inter-Plan Programs Policies and Provisions will require the following when a BlueCard provider engages in provider-based billing: (1) if the Host plan allows the provider-based billing and the Host plan provider contract allows provider-based billing as part of the fee schedule, BCBSVT will allow the claim to process to the member's benefits; (2) if the Host plan denies the provider-based billing and sends zero pricing, BCBSVT will deny the service as provider liability with no member responsibility; and (3) if the Host plan denies the provider-based billing and sends zero pricing and the provider is non-participating, BCBSVT will deny the service, but there may be member responsibility.



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Legislative Guidelines

38 C.F.R. § 17.101 (Collection or recovery by VA for medical care or services provided or furnished to a veteran for a nonservice-connected disability)

Related Policies

- Policy No. 07-04 Co-payments Operational Policy (internal use only)
- CPP_07 Observation Services Payment Policy

Policy Implementation/Update Information

Implemented February 1, 2016

Updated October 2017

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Approved by

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