

<b>Policy</b>	<b>REIMB_045</b>
<b>Effective Date</b>	<b>01/01/2026</b>
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Originated Department	Clinical Operations

### Provider Based Billing

<b>Audience</b>
Medical Management, Claims

<b>Purpose</b>
To ensure correct application of member benefits in claim processing.

<b>Definition</b>
<p>Provider based billing is a model used primarily in healthcare settings where outpatient services are provided in clinics that are considered part of the hospital or facility. This model allows hospitals or facilities to bill for both professional and facility charges that support higher reimbursement rates than traditional billing methods. Under this model the hospital is recognized as the main provider, and the additional facilities or clinics operate under its umbrella.</p>

<b>Policy/Procedure</b>
<p>The CO-OP's Vendor(s) and TPA(s) are required to configure benefit applications and claim processing rational to support correct member benefit communications, outline of benefit quoting calls, claims processing related to Provider Based Billing.</p> <p><b>Scope:</b> includes plans for members sold in all states, large group, small group, and individual.</p> <p><b>The CO-OP considers Provider Based Billing payable per CMS guidelines.</b></p> <ul style="list-style-type: none"> <li>Hospitals and facilities must comply with the provider-based billing rules outlined in 42 C.F.R &amp; 413.65. This includes ensuring that the clinics meet specific criteria related to their operation and integration with the main hospital.</li> </ul> <p><b>Location Requirements:</b></p> <ul style="list-style-type: none"> <li>Provider-based clinics can be located on campus (within 250 yards of the main hospital) or off-campus.</li> </ul>

- The clinic must be within 35 miles of the main provider unless the 75/75 test is met. This does not apply to a rural health clinic (RHC) and will not impact RHC reimbursement rates under the prospective payment system.
- A critical access hospital (CAH) provider-based clinic should not be within 35 miles of another hospital or provider-based department of a hospital since this would put the hospital's CAH status in jeopardy.

**Billing Structure:**

- When billing under the provider-based care model, patients will receive separate charges for:
  - Professional services billed by the professional provider on a 1500 claim form
  - Facility services (covering the use of the clinic room, equipment and associated resources, supplies, and support staff) on a UB claim form.

**Application of benefits related to provider-based billing of E/M services in claims processing includes:**

**Copay Plans:** Apply 1 copay per day for the office visit E/M service on copay plans based on providers' network status.

- Professional office visit E/M service billed by the professional provider on a 1500 claim form with place of service 11:
  - Copay plans apply copay to office visit E/M service.
- Facility related office visit E/M service (covering the use of the clinic room, equipment and associated resources, supplies, and support staff) on a UB claim form with place of service 19 and 22, 510-519 Revenue codes and PO modifier:
  - Copay plans apply no copay or member cost share to office visit, as copay taken on 1500 professional claim.

\*Ancillary services provided in addition to office visit E/M service, including medical and surgical services, apply member cost share per out line of coverage for both professional and facility claims. Preventive as preventive, medical as medical.

**NON-Copay Plans:** If not a copay plan, apply deductible and/or coinsurance for the office visit E/M service based on providers' network status.

- Professional office visit E/M service billed by the professional provider on a 1500 claim form with place of service 11:
  - NON-Copay plans-apply deductible and/or coinsurance per provider network status on the office visit E/M service.
- Facility related office visit E/M services (covering the use of the clinic room, equipment and associated resources, supplies, and support staff) on a UB claim form with place of service 19 and 22, 510-519 Revenue codes and PO modifier:
  - NON-Copay plans- apply no member cost share to office visit E/M service, as member cost share taken on 1500 professional claim.

\*Ancillary services provided in addition to office visit E/M service, including medical and surgical services, apply member cost share per out line of coverage for both professional and facility claims. Preventive as preventive, medical as medical.

**Codes:**

Office Evaluation and Management (E/M) Codes CPT codes	99202-992015
Facility Clinic Service Codes	Revenue codes 510-519 with HCPC code G0463 or CPT codes 99202-99215

**Violations**

TPA inaccuracies in processing claims, not using this benefit administration will result in claims processing errors, could impact Service Level Agreement (SLA) performance related to claims accuracy metrics. Future adjustments required to reprocess claims correctly will be at no cost to Mountain Health Co-Op.

**Medical Criteria**

Not Applicable

**References**

- Centers for Medicare and Medicaid Services, 42 C.F.R & 413.65  
eCFR :: 42 CFR 413.65 -- Requirements for a determination that a facility or an organization has provider-based status.

**Vendors**

- Health Plan Services (HPS)

**Review/Revision/Approval History**

Date	Description
<b>11/20/2025</b>	<b>Revisions with coding information</b>
<b>11/24/2025</b>	<b>Approved by Policy Committee</b>
<b>3/5/2026</b>	<b>Added place of service 22, approved by policy committee</b>

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