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Origination: February 1, 2016
Last Review: April 17, 2025
Next Review: April 17, 2026
Effective Date: August 1, 2025

Description

The intent of this payment policy is to communicate that Blue Cross Blue Shield of Vermont (Blue Cross VT) does **NOT** recognize provider-based billing, which is a method of billing Medicare for certain clinics owned or affiliated with a hospital. Under provider-based billing, the office/clinic visit is split into two bills. The facility bills a clinic charge for any facility or technical component on a UB-04/837I claim form and the professional services are billed separately on a CMS -1500/ 837P claim form.

Policy & Guidelines

Policy Statement

Blue Cross VT does **NOT** allow benefits for provider-based billing, as described in more detail below. This policy statement emphasizes all professional services provided in an office or clinic setting should be billed on a CMS-1500/ 837P claim form. A separate facility claim UB-04/837I should **NOT** be submitted for a facility or technical fees associated with the office /clinic visit.

Guidelines

Blue Cross VT will **NOT** provide benefits for a separate clinic fee, or any other facility fee associated with space used to provide Evaluation and Management (E/M), procedures and services. In the event these services are 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 the facility will be held financially liable for the charges.

Eligible E/M and other office-based procedures or services can be billed on a CMS-1500/837P with applicable place of service such as office (11) or outpatient (22). Place of service codes must accurately represent the place where the services were provided. If the services are delivered in a location different from the billing address, the location of the service must be identified on the claim.

NOTES:

When Submitting Claim as Medicare Primary

- The facility bills a clinic charge for any facility or technical component on a UB-04/837I claim form and the professional services are billed separately on a CMS-1500/ 837P claim form. Blue Cross VT will follow Medicare payment rules.

When Submitting Claim as Blue Cross VT Primary

- Facilities shall only submit a global bill for all services rendered in the clinic on a CMS-1500/837P claim form. Payment for professional services include any facility fees. Facility fees must **NOT** be billed separately on a UB-04/837I.

Eligible

Blue Cross VT may allow benefits for medically necessary services rendered by professional providers in a facility clinic when reported on a CMS-1500/837P.

Blue Cross VT does **NOT** recognize provider-based billing however, there are exceptions whereas benefits will be considered as noted below.

Noting the following scenarios below do **NOT** apply to this payment policy:

1. This policy does **NOT** apply if Medicare is primary and CMS guidelines require the submission of a UB-04/837I and CMS-1500/837P for provider based- billing as allowed by Medicare.
2. This policy does **NOT** apply in situations involving coordination of benefits with Medicaid to the extent following this policy would be inconsistent with Medicaid billing rules.
3. This policy does **NOT** apply to designated Veterans' Administration health care entities.
4. This policy does **NOT** apply to services provided in the Emergency Department. This means that Emergency Departments may bill separately for professional services and facility fees.

Not Eligible

The following instances are **NOT** billable and if billed will be denied as provider liability:

Examples include but **NOT** limited to E/M codes (G0463, 99202-99205, 99211-99215, 99381-99397) procedures and services performed during clinic visit.

- Type of Bill: 013X (Hospital Outpatient) AND
- Revenue Codes: 0510-0519

Examples include but **NOT** limited to codes (G0466-G0470) procedures and services performed during clinic visit.

- Type of Bill: 077X (Clinic - Federally Qualified Health Center (FQHC) AND
- Revenue Codes: 0521 OR 0528

General Ophthalmological Services codes in the range (92002-92014) with all revenue codes.

Benefit Determination Guidance

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

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 (Blue Cross VT 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. 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.

Medicare Primary Policies: Blue Cross VT Payment policies do not apply to any policies where Medicare is primary.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network

(participating/in- network) and any non-participating/out-of-network providers/facilities.

Audit Information

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory 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

Corporate Payment Policy CPP_07 Observation Services
Corporate Payment Policy CPP_12 Urgent Care Clinics
Corporate Payment Policy CPP_32 Claims Editing

Document Precedence

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

1) To the extent that there may be any conflict between the Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT Payment

Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Policy Implementation/Update Information

This policy was originally implemented on February 1, 2016

Date of Change	Effective Date	Overview of Change
	February 01, 2016	Policy Implemented
	October 01, 2017	Policy Updated
	January 01, 2021	Policy Updated
November 07, 2024		Payment policy updated new template format, no changes to policy statements. Removed deleted codes 99201 & 99241 from coding within policy.
April 17, 2025	August 01, 2025	Payment policy updated new template format. Clarification to policy statements surrounding type of bill, and place of service to restate the actual policy intent. Removed deleted codes 99201 & 99241 from coding within policy. Updated the description section, policy statements and general sections to offer more clarification and detail to expectations noting policy statement intent remains unchanged. Under Not Eligible Section updated and clarified the following: The following instances are NOT billable and if billed will be denied as provider liability: Examples include but NOT limited to E/M codes (G0463, 99202-99205, 99211-99215, 99381-99397) procedures and services performed during clinic visit. • Type of Bill: 013X (Hospital Outpatient) AND • Revenue Codes: 0510-0519 Examples include but NOT limited to codes (G0466-G0470) procedures and services performed during clinic visit

		• Type of Bill: 077X (Clinic - Federally Qualified Health Center (FQHC) AND • Revenue Codes: 0521 OR 0528 General Ophthalmological Services codes in the range (92002-92014) with all revenue codes. Updated Related Polices Section.

Approved by **Update Approved: 04/17/2025**

Tom Weigel, MD, Chief Medical Officer