



State of Vermont
Agency of Human Services
280 State Drive, Center Building
Waterbury, VT 05671-1000

Global Commitment Register

May 16, 2016

GCR 16-041
PROPOSED

Elimination of Provider-Based Billing for Hospital-Owned Clinics

Policy Summary:

The Department of Vermont Health Access proposes to eliminate Provider-Based Billing for hospital owned provider-based clinics. On-campus and off-campus hospital-based clinics that have provider-based status under 42 C.F.R. § 413.65 will no longer be allowed to bill a separate and additional “facility charge” in connection with clinic/office visit services performed by a physician or other medical professional.

More detailed information for providers regarding this change can be found below in the *Additional Information* section.

Effective Date:

July 1, 2016

Authority/Legal Basis:

These changes are being made under the Medicaid State Plan, which can be found here: <http://dvha.vermont.gov/administration/state-plan>.

Population Affected:

All Medicaid

Fiscal Impact:

This change in billing policy will be coupled with an Outpatient Prospective Payment System (OPPS) rate increase, also effective 7/1/16. The overall fiscal impact will be budget neutral.

Public Comment Period:

5/16/16 – 6/15/16

Send comments to:

Agency of Human Services
Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, VT 05671-1000

Or submit via e-mail to AHS.MedicaidPolicy@vermont.gov.

There is no public meeting scheduled at this time. If one should be scheduled, that information can be found at: <http://dvha.vermont.gov/> either through the calendar or listed under upcoming events.

Comments received will be posted to the [proposed GCR policy page](#) by July 1, 2016.

Additional information:

The 51x clinic revenue code series along with code G0463 (hospital outpatient clinic visit) will no longer be covered or reimbursed by DVHA. In addition, E&M codes 99381-99397 (well visits) will no longer be reimbursed when billed on a UB-04 (facility) claim type, and 99201-99205, 99211-99215 will remain non-reimbursable when billed on a UB-04 claim type as these codes represent professional services provided in an office or clinic setting.

Professional services provided in a provider-based clinic setting as of 7/1/16 are required to be billed on the CMS-1500 (professional) claim form. The facility components of the clinic/office should no longer be billed separately on a UB-04 facility claim (also known as split billing). The facility components of the clinic/office visit should now be billed as part of the physician claim and will be subject to reimbursement under our RBRVS physician payment methodology.

The provider-based clinic must submit to DVHA a CMS-1500 (paper) or 837P (electronic) claim form containing both of the following:

- The facility and professional fees
- The place of service 11 (office)

Services performed in a hospital outpatient department (non-clinic setting) should continue to be billed on both a CMS-1500 (professional claim) and UB-04 (facility claim) as appropriate. In this circumstance, the professional claim must be billed with the appropriate outpatient place of service if there is a corresponding facility claim being billed.

For outpatient services performed in a non-clinic setting, when billed on both a CMS-1500 and UB-04, the place of service 11 (office) should not be used on the corresponding professional claim. Place of service 11 should only be used when the professional and facility charges are submitted together on the professional claim. If a place of service 11 were submitted on a split bill, the professional claim would be inappropriately reimbursed at a higher non-facility rate which would be duplicative of the corresponding facility (APC) payment.