Provider Based Billing

E&M Services – Institutional Setting

Policy and General Information

This policy describes Community Health Options' rules regarding professional and facility reimbursement for Evaluation & Management (E&M) services when those services are provided in an institutional setting (hospital campus), versus a non-institutional setting, as defined by the place of service setting and bill type.

E&M services for this policy are defined as professional services that are performed by a licensed physician, or other qualified healthcare professional, to assist with the prevention, diagnosis or treatment of illness, or maintenance of ongoing health.

Site of service – Institutional Setting: The primary site or campus of a hospital, or other institutional setting (a facility), that includes state licensed inpatient beds, and/or a state licensed emergency department, and may also have provisions for continuous care onsite, both physician and nursing, further defined as care accessible twenty-four (24) hours per day, seven (7) days per week.

Site of service – Professional Setting: Services that are rendered in an office setting, a separate and distinct office building, or any clinic or space owned by a hospital or facility that is not contained within the primary structure of the hospital or facility. Non-institutional settings include spaces rented by professional providers from the hospital or facility.

Applicable Community Health Options referral, notification and authorization policies and procedures apply.

Provider Billing Guidelines

Maine Statute MRSA 24-A, Chapter 18, §1912, "Standardized Claim Forms", addresses the claim form billing requirements for professional services, and notes that "For the purposes of this section, "office setting" means a location where the health care practitioner routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis whether or not the office is physically located within a facility."

Services that are rendered in a Professional Setting must be billed on a CMS-1500 claim form. Professional services billed on a UB-04 claim form for non-institutional settings will not be reimbursed.

Community Health Options will not reimburse for any separate and distinct fees (clinic or facility) billed on a UB-04 claim form, regardless of site of service, when E&M services are provided to Covered Persons.

Covered Persons are not responsible for non-reimbursed charges associated with this policy.

Provider Revenue Code Considerations

Examples of Revenue Codes under which services will not be reimbursed and should not be billed include, but are not limited to, the following Revenue Code groups:

0280-0289	Oncology Clinic
0300-0309	Laboratory
0310-0319	Laboratory Pathological
0320-0329	Radiology Diagnostic
0330-0339	Radiology – Therapeutic and/or Chemotherapy Administration
0340-0349	Nuclear Medicine
0350-0359	CT Scan
0420-0429	Physical Therapy

0430-0439	Occupational Therapy
0440-0449	Speech Therapy
0481-0489	Cardiology Clinic
0510-0519	Clinic
0520-0529	Freestanding Clinic
0530-0539	Osteopathic Services
0540-0549	Ambulance Services
0610-0619	Magnetic Resonance Technology
0630-0637	Pharmacy
0740-0749	Sleep Study
0760-0769	Treatment or Observation Room
0770-0779	Preventive Care
0780-0789	Telemedicine
0960-0989	Professional Fees

Other Considerations

All professional services must be billed on a CMS-1500 claim form, utilizing CPT®/HCPCS® codes to appropriately identify the rendered services. Professional services include those provided by, but not limited to, hospital-based physicians, radiologists, hospitalists, emergency room physicians, anesthesiologists, Certified Registered Nurse Anesthetists (CRNA), independent practitioners, physical therapists, occupational therapists, and speech therapists.

Document Publication History

10/30/17	Initial document created
01/01/18	Policy effective date
03/04/19	Revision to clarify Revenue Code considerations

This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion.