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Agency of Human Services

Date: June 22, 2016

Re: Public comment received for GCR 16-041 Elimination of Provider Based Billing for Hospital-Owned Clinics

In response to enclosed comment, DVHA has modified its guidance related to the elimination of provider-based billing for hospital-owned practices that have been granted provider-based status under 42 C.F.R. § 413.65. The modified guidance can be found in the final policy, available here: http://dvha.vermont.gov/global-commitment-to-health/gcr-16-041-elimination-of-provider-based-billing.pdf.

Rutland Regional Medical Center
An Affiliate of Rutland Regional Health Services

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May 26, 2016

Agency of Human Services
Medicaid Policy Unit
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Re: Rutland Regional Medical Center (RRMC) Comment – GCR 16-04, Proposed

We are providing this comment letter to request that the Department Vermont Health Access (DVHA) clarify that the scope of the policy change to eliminate provider-based billing is limited to the "51x clinic revenue codes series. The guidance that DVHA has circulated includes confusing and potentially contradictory language that could be interpreted to include a scope of services that is much broader than 51x services. DVHA's financial modeling was limited to 51x services and therefore a more expansive policy would be not supported by analysis and would therefore be inherently arbitrary.

The Policy Summary and Additional Information released on May 16, 2016 describes the scope of the change with three potentially conflicting criteria; (1) services reported with revenue code 51x, (2) services provided in a clinic setting, and (3) clinic/office visit services. The Vermont Medicaid Banner released on May 23, 2016 further complicates the scope of the change by adding the term "facility charge." Medicare and Medicaid use the term "clinic" to describe a variety of settings and services so we believe services reported with revenue code 51x should be the sole criterion used to describe the scope of the policy. The use of revenue code 51x provides a precise and clearly established scope for the policy. However, our concern is that the use of imprecise and undefined terms to delineate the scope of the policy could lead to operational and financial inconsistency and potential conflict.

As described in the Additional Information section, we understand the scope of the policy change to apply to the "51x clinic revenue codes series." The E&M code examples included in the Additional Information section and repeated in the Banner reinforce the scope of the policy that is limited to 51x services. Our understanding is also based on the fact that DVHA's fiscal modeling is limited to the 51x revenue code and the analysis excludes other revenue codes. We recognize that DVHA could not implement a policy at this time that extends to other revenue codes because there is no fiscal analysis to support a more expansive policy and therefore the policy would be inherently arbitrary.

The Additional Information section becomes confusing, however, where it states that "[s]ervices performed in a hospital outpatient department (*non-clinic setting*) should continue to be billed on both the CMS-1500 . . . and UB-04 as appropriate." The statement is preceded by the guidance which states "[t]he facility components of the

clinic/office [sic] should no longer be billed separately on a UB-04 facility claim." The Banner further complicates the issue by stating that "[o]n-campus and off-campus hospital-based clinics that have provider-based status . . . 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." The use of the phrases "facility components," "facility claim" and "facility charge" could encompass a much broader scope of services than 51x type services and result in significant financial implications that are not including in the modeling performed by DVHA.

We have additional concerns regarding the Banner's reference to "on-campus and off-campus" clinics "with provider-based status." The off-campus designation creates a distinction between (1) off-campus provider-based departments and (2) provider-based departments that are within the four walls of the main hospital building or on the main hospital campus. There is no rule or mechanism to distinguish between within the four walls and on campus provider-based departments. Off-campus provider-based departments and services are clearly distinguishable from other departments and services because of the 250 yard boundary and the fact that Medicare and Medicaid require off-campus services to be reported with place of service 19 on 1500 claim and a PO modifier on the UB-04 claim. However, services performed in provider-based departments within the four walls of a hospital or on the main hospital campus are not distinguishable. There is no way to distinguish between services on a claim that were provided within the four walls from services that were provided on-campus and there is often no significant operational distinction. 51x services, however, are clearly distinguishable from other services. The only other mechanism to draw a clear policy line is the off-campus designation created by Medicare that is referenced in Section 3 of S. 245.

We believe DVHA's intent was to use the type of service – services reported with a revenue code 51x – to determine how the claim should be billed. Implementing a billing instruction that is based on all 51x services should ensure consistency in operations and financial analysis because it is based on a clearly established definition and the services are easily identifiable on a claim. The use of the undefined and inconsistently utilized terms "clinic," "clinic/office," "non-clinic" and "facility charge" introduce unnecessary ambiguity because Medicare uses the term clinic to describe both services provided in hospital outpatient departments and free-standing physician offices and clinics.[1] Medicare's provider-based billing rule is clear, despite its inconsistent use of the term "clinic" because it does not use the undefined term "clinic" to describe the scope or application of the rule. Rather, CMS consistently uses the defined terms "free-standing" and "provider-based," which are tied to the corresponding use of place of service 11 and 22 respectively. *See* 42 CFR § 413.65(a)(2).

[1] For example, Medicare uses the term clinic to include both 51x services provided in hospital outpatient departments that are reported with a place of service 22 and also uses the term "clinic setting" to mean services furnished in a free-standing physician office that is reported with place of service 11. *See Medicare Claims Processing Manual*, 100-04, Ch. 12, section 30.6.1 *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf*

We have enclosed a series of billing scenarios, which we believe is consistent with DVHA's intent to eliminate provider-based billing for services that are reported with revenue code 51x and to continue the use of other revenue codes "[s]o that services performed in a hospital outpatient department (non-clinic setting) [non-free-standing provider-based setting] should continue to be billed on both a CMS-1500 (professional claim) and UB-04 (facility claim) as appropriate."

- Scenarios 1, 2, and 3 describe a physician evaluation and management service (E&M) revenue code 510 services provided in provider-based departments (1) within the four walls of the hospital, (2) on the main hospital campus, and (3) in an off-campus department. The service in its entirety would be billed on a professional claim (1500) with a place of service 11 or a place of service 19 and there would be no corresponding facility claim (UB).
- Scenario 4 describes a service if it were billed in accordance with Section 3 of S.245. It involves a surgical procedure performed in an off-campus provider-based department. The service in its entirety would be billed on a professional claim (1500) with a PO modifier and there would be no corresponding facility claim (UB). We understand that DVHA has not issued instructions to implement this policy change. However, based on the off-campus distinction the policy would be feasible to model and implement as opposed to a policy that seeks to distinguish between hospital and on-campus services.
- Scenario 4 describes a surgical procedure performed in a provider-based hospital outpatient department that is either within the four walls of the main hospital building or is on the main hospital campus. The surgical service is billed on professional claim (1500) with a place of service 22, and the facility services are billed on a facility claim (UB).

Thank you for your consideration.

Respectfully submitted

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Enclosure

Billing Scenarios	Billing CPT/Rev Code	Financial Model Column	Proressional Claim Billed YES or NO	Place of Service	Facility Claim YES or NO
1 Patient sees provider for Office Visit E&M Clinic space is located within the 4 walls of the main hospital Space is designated a Medicare Provider based Clinic	Current: 99213/510 Rev Code Proposed: 99213/960 Rev Code	E	(YES) or NO	11	YES or (NO)
2 Patient sees provider for Office Visit E&M Clinic space is located in building within 250 yards of the main hospital Space is designated a Medicare On Campus Provider Based Clinic	Current: 99213/510 Rev Code Proposed: 99213/960 Rev Code	E	(YES) or NO	11	YES or (NO)
3 Patient sees provider for Office Visit E&M Clinic space is located in building outside 250 yards of the main hospital Space is designated a Medicare Off Campus Provider Based Clinic	Current: 99213/510 Rev Code Proposed: 99213/960 Rev Code	E	(YES) or NO	19	YES or (NO)
4 Patient sees provider for planned procedure only Service is rendered in Off Campus Provider Based Clinic	Surgical CPT /960 Rev Code	A	(YES) or NO	19	(NO)
5 Patient sees provider for planned procedure only Service is rendered in a Provider Based Dept within 4 walls of hospital or on main hospital campus	Surgical CPT /960 Rev Code Surgical CPT /360 Rev Code	A	(YES)	22	(YES)