SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.33 PROVIDER-BASED BILLING

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

PROVIDER-BASED BILLING

Blue Cross does not recognize provider-based billing, which is a method of billing Medicare for certain clinics owned or affiliated with hospitals. 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 claim form and the professional services are billed separately on a CMS-1500 claim form.

We do not recognize provider-based billing of office services even if the office is located on the hospital campus and/or uses the hospital Tax ID number.

All professional services in an office or clinic setting should be billed on the CMS-1500 claim form with an "office" place of service "11." A separate facility claim on a UB-04 should not be submitted for a facility or technical fee associated with the office/clinic visit.

Facilities operating provider-based clinics should submit a global bill for all services rendered in the clinic on a CMS-1500 claim form. Payment for the professional provider's services includes any technical or facility fees.