

Reimbursement Policy

Hospital-Based Clinic Billing

REIMBURSEMENT POLICY NUMBER: 29

Effective Date: 6/1/2026

Last Review Date: 2/2026

Next Annual Review: 1/2027

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INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

All health care services billed on UB04 forms (CMS 1450)

Plan Product:

- Commercial
- Medicare
- Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as “Company” and collectively as “Companies”).

NOTE: For **Commercial** plan members, the Company does **not** follow Original Medicare reimbursement methodology which allows split billing of provider-based services.

- I. For **Commercial** members, facility clinic charges billed under revenue codes (0510-0530) will **not** be allowed separate reimbursement when billed with professional charges on the same service date, regardless of location (POS 19 [**off**-campus outpatient hospital] or 22 [**on**-campus outpatient hospital]) or tax identification usage.
- II. If the hospital can demonstrate actual hospital services were rendered on the date in question (e.g., services provided in a wound clinic or dialysis clinic, etc.), the Company may allow separate reimbursement for those services according to provider contract agreements.
- III. If payment is made inadvertently, recovery efforts may be made to recoup the erroneous payment.

POLICY GUIDELINES

DEFINITIONS

POS. Place of service

POS 19. Place of service for off-campus outpatient hospital.

POS 22. Place of service for on-campus outpatient hospital.

BACKGROUND

The Company reimburses providers for facility charges on the basis of the reasonable cost of the care or reasonable charge for the facility services. While we acknowledge Original Medicare allows this billing methodology, the Company does not consider facility charges for hospital-based outpatient clinics (revenue codes 510-0530) to represent reasonable covered services under provider contract agreements. Thus, these charges are **not** eligible for separate reimbursement.

NOTE: This includes facilities contracted to reimburse under a percentage of billed charges agreement. Such agreements are not meant to imply that all billed charges will be considered “reasonable.”

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 1/29/2026, the following Centers for Medicare & Medicaid (CMS) references were identified which address provider-based billing:

- Noridian web page for Provider Based Facilities

- CMS Change Request (CR) 9231
- CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 20.6.6.11
- CMS Internet Only Manual (IOM), Publication 100-05, Medicare Secondary Payer Manual
- CMS Change Request (CR) 9613
- CMS CR 11099 - January 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- CMS Program Memorandum A-03-030
- CMS Medicare Learning Network (MLN) Special Edition (SE)19007 - *Activation of Validation Edits for Providers with Multiple Service Locations*
- 42 CFR 413.65 (d) (e) - *Federal Register Provider-Based Definitions*

However, the Company does **not** follow Original Medicare reimbursement methodology which allows split billing of provider-based services.

BILLING AND CODING GUIDELINES

Modifiers

Modifier PN: Non-accepted service provided at an off-campus, outpatient, provider-based department of a hospital

Modifier PO: Accepted service provided at an off-campus, outpatient, provider-based department of a hospital

CROSS REFERENCES

None

The full Company portfolio of current Reimbursement Policies is available online and can be [accessed here](#).

REFERENCES

1. Noridian Healthcare Solutions (Noridian) Jurisdiction F (JF). Provider Based Facilities. <http://med.noridianmedicare.com/web/jfa/provider-types/provider-based-facilities>. Accessed 1/29/2026.
2. CMS Change Request (CR) 9231. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3315CP.pdf>. Accessed 2/9/2026.

POLICY REVISION HISTORY

Date	Revision Summary
6/2026	New Reimbursement Policy