



Professional Services

Reimbursement Policy

Purpose

To provide clarification on professional services and appropriate billing guidelines.

Policy

Community Health Options (“Health Options”) follows national standards for completing the claim forms as follows:

- UB-04 (CMS-1450) paper claim and electronic 837I (institutional claim) for technical/hospital facility services based on the National Uniform Billing Committee (NUBC).
- CMS-1500 paper claim and electronic 837P (professional claim) for physician, non-physician practitioner, and other healthcare provider professional services based on the National Uniform Claim Committee (NUCC).

The technical component of a charge addresses the use of equipment, facilities, non-physician medical staff, supplies, etc. Technical charges do not include the physician's professional fees but includes the use of all other services associated with the visit.

The professional component of a charge covers the cost of the physician’s professional services. Professional services 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. Professional services are reimbursed using a fee schedule. Examples of professional services include (not all-inclusive):

- Anesthesia professional services
- Ambulance services
- Behavioral health
- Evaluation and Management
- Image readings (CT, MRI, X-ray, etc.)
- Medication Assisted Treatment
- Physical, occupational, and speech therapies
- Physician Assistant (PA)
- Surgical professional services and Assistant surgeon services

Other services required to be billed on the CMS-1500 (837P) claim form may be facility type based or service type-based services that are paid based on a fee schedule. Durable Medical Equipment (DME) is an example of service type-based services to be billed on the CMS-1500 (837P) for appropriate reimbursement.

Revenue Codes

UB-04 (CMS-1450) revenue codes identified as “Professional Fees” by NUBC will not be considered for reimbursement by Health Options unless billed on the CMS-1500 (837P) for appropriate reimbursement. Example revenue codes include (but not all-inclusive):

0960-0969 Professional Fees

0970-0979 Professional Fees

0980-0989 Professional Fees

Other revenue code categories, where professional services can be found, that should be billed on the CMS-1500 (837P) claim form includes, but are not limited to, the following:

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 and other Specialty Services

0770-0779 Preventive Care Services

0780-0789 Telemedicine

0900-0919 Behavioral Health Treatments/Services

Place of Service

The “Place of Service” (lines 1-6, CMS-1500 form location 24B) identifies the location where the service was rendered. This field allows for the entry of 2 digits in the unshaded area. Place of Service Codes are available at: http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Exceptions

Health Options accepts Ambulatory Service Center (ASC) claims to be billed using the UB-04/CMS-1450 claim form.

Conclusion

All professional services must be billed on a CMS-1500 claim form (electronic 837P), 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), clinical psychologists, independent practitioners, physical therapists, occupational therapists, and speech therapists.

Related Policies

Anesthesia Professional Services	Outpatient & Professional Service Edits
Clinic Charges	Paper Claims Submission
Facility Revenue Code Requirements	Payment Integrity Audit
Medication Assisted Treatment	Physician Assistant Services

Document Publication History

6/30/2022 Annual review; no update

7/9/2021 Initial publication; policy replaces the previously published Provider Based Billing Policy that was effective 1/1/2018.

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. Policies are enforced unless underpinning direction stated otherwise.