# Benefits Cost Management

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Pennsylvania Blue Shield’s Benefits Cost Management department monitors and controls reimbursements:

- To facility-based providers and to provider-owned and operated free-standing facilities.
- For total charge diagnostic or therapeutic services — including services that utilize high-cost technology equipment.

Blue Shield has adopted a special method of reimbursement for several services that utilize high-cost equipment. This reimbursement method monitors and controls costs by basing payments on a provider’s total cost.

This methodology is utilized only when these services are provided in a free-standing setting. Through documentation and on-site reviews, Blue Shield limits payments to reasonable costs, such as those that would reflect the fair market value of the equipment.

Cost reimbursement for high-cost equipment

Blue Shield requires providers who plan to request total charge reimbursement for services provided on high-cost equipment to contact Benefits Cost Management prior to submitting these claims. We consider equipment such as computed tomography (CT), magnetic resonance imaging (MRI), linear accelerators, positron emission tomography (PET) or any other equipment valued at $250,000 or more, as high-cost technology.

Total charge reimbursement of high-cost technology services includes the professional and technical components. The technical component involves the calculation of the:

- **Machine component** — the costs specific to each practice relating directly to the acquisition and installation of the medical equipment.
- **Non-machine component** — the indirect costs associated with performing the service, such as utilities expense.

Out-of-state, high-cost technology

Out-of-state, high-cost technology services are not reimbursed on a cost-related basis. Physicians reporting these services to Blue Shield are generally entitled to total charge reimbursement as long as the services are performed in an office setting. Services performed for a hospital patient (inpatient or outpatient) will be reimbursed only at the professional component level.

Corporations and partnerships

Due to the expense involved in purchasing high-technology medical equipment, and the emergence of imaging centers offering a variety of high-cost technology services, many physicians are incorporating or forming partnerships with businesses to provide these services. Benefits Cost Management works closely with the Provider Relations areas to ensure that only approved group billing entities are reimbursed by Blue Shield.

Avoiding duplicate payments to physicians in facilities

Blue Shield and the state’s Blue Cross Plans work together to avoid duplicate payments for services rendered in a facility, such as a hospital or skilled nursing facility.

Because of the number of physician arrangements and the number of physicians who also have separate offices outside of facilities, this effort requires extensive monitoring of claim submissions and continual payment coordination between Plans.
Blue Shield defines four classifications of facility-based physician practices:

- Facility-based compensated practice (also referred to as hospital compensated doctor) — a physician compensated by a facility for services through an annual salary or on a fee-for-service basis. The costs for these services are normally considered hospital costs; therefore, they are a Blue Cross liability.
- Facility-based, previously compensated practice (also referred to as hospital-based, previously compensated practice) — a compensated physician who has elected to change his or her arrangement with a facility and bill Blue Shield directly on a fee-for-service basis.
- Facility-based private practice (also referred to as hospital-based private practice) — a physician whose practice is located in a facility. The physician leases office space from the facility. All technical charges, including utilities, salaries, equipment purchases and supplies (office and medical) are the responsibility of the physician, rather than the facility. The physician bills Blue Shield directly on a 1500 claim form.
- Facility-compensated satellite office practice — a physician compensated through an annual salary or on a fee-for-service basis by a facility for services performed in the facility owned satellite practice that has been approved by Benefits Cost Management as an “office practice site.”

**Services provided in a teaching setting**

Benefits Cost Management also audits physician documentation of services provided in a teaching setting. For a service to be billable to Blue Shield, it must meet the requirement of being an identifiable physician service to an individual patient.

Services that are furnished by the resident or by the teaching physician for the general benefit of patients, that is, supervising and teaching of residents, cannot be billed to Blue Shield.

**Professional component vs. total charge billing**

Benefits Cost Management monitors professional component and total charge payments to hospital-based physicians.

These payments are defined as:

- **Professional component** — the charge that represents the physician’s involvement. It is generally considered to be the interpretation of the results.
- **Total charge** — the charge for a diagnostic study that involves both the professional and technical components.

The physician must have total responsibility for overhead and related costs in order to bill the total charge for diagnostic and therapeutic services.

**Defining inpatient and outpatient**

When you submit claims to Blue Shield for diagnostic or therapeutic radiology services or diagnostic medical services provided to hospital inpatients or outpatients, you must report the place of service as inpatient hospital or outpatient hospital, as appropriate. In these cases, Blue Shield will reimburse the professional component only. For purposes of this requirement, here is how we define inpatient and outpatient:

- **Inpatient** — a patient who is an inpatient of a facility, such as a hospital or skilled nursing facility, at the time the procedure is performed.
**Outpatient** — a patient, other than an inpatient, who is treated in a hospital, on hospital grounds or in a hospital-owned or controlled satellite, when that satellite has been determined to be a Blue Cross payment responsibility. This definition does not apply when a treating physician’s sole practice is located in a hospital or hospital owned building, if the practice is not affiliated or controlled, in any way, by the hospital or a related entity; or, if the practice has been approved by Benefits Cost Management to be recognized as an office practice.

For example, if a mobile ultrasound, MRI or CT unit locates on hospital grounds one day each week, all services provided to patients on that day must be reported with inpatient or outpatient, but not office, as the place of service.

When an inpatient is taken outside the hospital setting, such as to a physician’s office, and is then returned to the hospital, the physician must report services to Blue Shield according to the patient’s status, in this case, inpatient. For services provided to hospital inpatients, you must report only “inpatient” as the place of service, rather than the place, such as “office” or “outpatient hospital,” where the service actually was performed.

**Medical direction of anesthesia services**

A professional provider may bill Blue Shield for the medical direction of certified registered nurse anesthetists’ (CRNA) services. If the professional provider employs the CRNA, payment is made in the same manner as the professional provider’s personal performance of the service.

However, if the professional provider does not employ the CRNA, Blue Shield reimburses up to 50 percent of the allowance for the full service.

Benefits Cost Management monitors and controls Blue Shield’s payment of medically directed CRNA services. Professional providers are required to provide proof of CRNA employment to Benefits Cost Management prior to billing for their services. All claims for services of CRNAs employed by professional providers must be held until Benefits Cost Management advises the provider that they have been approved to submit them.

Approval for full reimbursement of anesthesia services will be contingent upon meeting employment criteria established in accordance with Blue Shield policy. Reimbursement will be limited to 50 percent of the full allowance until the approval process is complete.

**Quality of imaging films**

Blue Shield will periodically conduct reviews of imaging films to ensure the quality of services provided to Blue Shield members. Films, selected at random, will be reviewed by an appropriate professional consultant.