

Understanding Facility and Non-Facility Pricing (Site-of-Service Differential)

Effective October 1, 2010

Blue Cross and Blue Shield of Alabama believes there are several factors that must be considered in order to appropriately compensate physicians for the services they provide our members. Effective October 1, 2010, Blue Cross fee schedules will take into account the resources cost for providing services. In determining the value of a procedure, each physicians' "Current Procedural Terminology" (CPT) code has been given a relative value unit (RVU). The RVU for each procedure is based on the components explained below:

Physician Work reflects the physician's time, skill and intensity required for the service.

Practice Liability Expense reflects the professional liability or malpractice expense to the physician to provide a service.

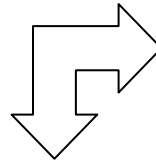
Practice Expense reflects the cost of the physician's practice overhead, including rent, staff salaries and benefits, medical equipment and supplies.

Appropriate compensation is based on the provider's costs that are associated with performing a given procedure in a particular setting [e.g., physician's office, hospital inpatient, outpatient, ambulatory surgery center (ASC), etc.]. The *Practice Expense* component may be different when a procedure is performed in a "non-facility" setting as opposed to a "facility" setting, commonly known as a site-of-service differential. In most cases, the provider's practice expenses in the office setting are higher than in a hospital setting. Below is an explanation of these two categories:

- **Non-Facility Practice Expenses** represent the provider's direct and indirect costs related to providing that service in the physician's office, patient home or other non-facility setting. Expenses may include rent for office space, employees, supplies, equipment, etc.
- **Facility Practice Expense** represents the provider's direct and indirect cost of providing a service in a facility setting. The expenses of rent, supplies, labor and equipment are part of the cost of the facility where the service is being rendered.

Taking into account the "cost to the provider" may result in a different payment for the same procedure when performed in different settings. Effective October 1, 2010, Blue Cross will no longer identify procedures for an "incentive" payment when performed in the office setting rather than the outpatient or facility settings. Procedure codes listed on Exhibit F of the PMD agreement will be removed based on the new facility/non-facility pricing. Click **here** to view Exhibit F.

The fees will be reflected on the fee schedule in the following way:



Facility – Provider payment for services rendered in the hospital (inpatient or outpatient), ASC or other type facility are shown here.

Preferred Medical Doctor Fee Schedule

Type Service	Procedure Code	Facility Fee \$	Non-Facility Fee \$
2	12345	\$XX.XX	\$YY.YY
2	22345	\$XX.XX	\$YY.YY
2	32345	\$XX.XX	\$YY.YY
2	42345	\$XX.XX	\$YY.YY
2	53345	\$XX.XX	\$YY.YY
2	63345	\$XX.XX	\$YY.YY
5	73345	\$XX.XX	\$YY.YY
6	99213	\$XX.XX	\$YY.YY

Non-Facility – Provider payment for services performed in the physician’s office or non-facility location is located in this column. Payment may be higher to account for the additional direct and indirect costs for rendering the service in this setting.

