The below information applies to services at the CRMC Foot and Ankle Clinic, a Hospital Outpatient Department of Cherokee Regional Medical Center.

What is provider-based billing?
Provider-based billing is a type of billing for services rendered in a hospital outpatient department including a medical office. This billing model is also known as hospital outpatient billing.

Why provider-based billing?
Provider-based billing is used by many integrated (hospital and medical office) health care systems across the nation. Patients benefit because all hospital outpatient departments are subject to additional stringent quality standards and are monitored by The Joint Commission, an independent, not-for-profit organization that accredits and certifies more than 21,000 health care organizations and programs in the United States. The Centers for Medicare and Medicaid Services have separate payment programs for provider-based billing and require us to make it clear to our patients which health care services are part of the hospital.

How does provider-based billing affect the billing process?
For patients with certain insurance coverage, your Explanation of Benefits from your insurance carrier will show for each visit:

- One charge for the professional services rendered by the provider (Physician, Physician Assistant, or Nurse Practitioner) you see; and,
- One charge for the facility, which covers the use of the room and any medical or technical supplies, equipment and support staff.

For most patients, both charges add up to the same amount previously charged to all patients for the same service.

Which Cherokee Regional Medical Center (CRMC) locations are provider-based?
Effective January 1, 2020, the CRMC Foot and Ankle Clinic is using provider-based billing. This is because health care services provided in that clinic will be considered hospital outpatient services.

Will there be a change in how I receive care?
No – how you receive care remains the same. You will continue to receive excellent quality care from the same providers you have come to know and trust. Scheduling for appointments will not change.

Are all patients billed using provider-based billing?

The requirement to separately list professional services and facility charges for each office visit or service is required by the Centers for Medicare and Medicaid Services. Only patients with Medicare, Tricare, Medicaid and select Medicare Advantage plans are billed with the separately listed professional and facility charges. Other payers, such as commercial insurance companies, do not require charges to be shown and billed separately.

Will provider-based billing increase the cost of care for Medicare, Medicare Advantage, Medicaid or Tricare covered patients?
Cost of care will depend on the particular insurance coverage. Benefits may be different for certain outpatient services at a provider-based billing location. Some Medicare patients may be covered by supplemental insurance and may not have to pay more out-of-pocket.
Medicare beneficiaries are responsible for the co-insurance amount on the services received. The co-insurance amounts are determined by Medicare and based on the services performed.

What if I have Medicare with secondary insurance coverage?
Coinsurance and deductibles are generally covered by secondary insurance. Check your benefits or contract your insurance company for details.

Does this affect co-pays or deductibles?
This will depend upon each patient's specific insurance benefits. Additional out-of-pocket expenses may be incurred in a provider-based clinic.

Can I get an estimate?
We can estimate your out-of-pocket costs by contacting our Business Office at 712.225.1504. For questions about provider-based billing, you can call 712.225.1504.