Outpatient Facility Fee Schedule

Policy

This policy applies to hospitals and ambulatory surgical centers contracted under the standard Harvard Pilgrim Outpatient Facility Fee Schedule that is based on the Medicare APC methodology.

- Other policies within this provider manual will apply to hospitals and ambulatory surgical centers contracted under this standard fee schedule except as detailed below.
- Some of the information in this Policy may not be applicable to all facility types.

Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies and procedures apply. (Refer to *Referral, Notification and Authorization* for more information.)

HMO/POS/PPO

Open Access HMO and POS

For *Open Access HMO and Open Access POS* products, no referral is required to see a contracted specialist.

Harvard Pilgrim Reimburses[1]

HMO/POS/PPO

Outpatient Services

- Outpatient services may be reimbursed on a fee for service basis, unless otherwise specified.
- Outpatient services billed on a paper UB04 or electronic 837I will only be reimbursed when submitted with both a revenue code and a valid CPT/HCPCS code. Claim lines submitted without a valid CPT/HCPCS code will not be separately reimbursed.
    - *Exception:* CPT/HCPCS is not required for Observation Rev Codes 0760, 0762, or Dialysis Rev Codes 0821–0889.

Emergency Room Services

Emergency room (ER) care is reimbursed at a contracted rate, including:
- Facility services directly related to the services provided as part of the emergency room care.
- Procedure(s) performed in the emergency room setting.

Harvard Pilgrim reimburses the following services separately from the contracted rate:
- Ancillary services such as laboratory, pathology, radiology, etc., that support the services provided.
- Procedure(s) performed outside of the ER setting (i.e., operating room, ambulatory surgery, clinic, treatment room). (Refer to "Outpatient Surgery/Significant Procedures" below for more information.)

Observation Stay

Observation stay is reimbursed at a contracted case rate and includes all facility services provided as part of the observation stay including but not limited to pharmacy, supplies, and ancillary services, such as laboratory, pathology, radiology, etc. (Refer to *Observation Stay* for more information.)

Emergency room services preceding observation stay
- When emergency room precedes an observation stay, the entire emergency episode is included in the observation reimbursement for inclusive payment according to the contracted observation rate.

Outpatient surgery/significant procedures related to observation stay
- Observation services billed in conjunction with outpatient surgery or other significant procedures are considered part of the procedure and no separate observation reimbursement will be made.

Outpatient Surgery/Significant Procedures

Outpatient surgery/significant procedures are reimbursed at a contracted rate, including:
- Facility services that are directly related to the procedure performed including but not limited to anesthesia, operating room, recovery room, observation room, implantable device, most pharmacy and supplies.
- Harvard Pilgrim reimburses professional services separately (i.e., surgical, pathology, radiology, anesthesiology, etc.) in accordance with the related plan fee schedule when provided by an In-Network participating provider.
- Harvard Pilgrim reimburses the following services separately from the contracted rate:
  - Ancillary services such as laboratory, pathology, radiology, consistent with the fee schedule.
  - Emergency room (ER) care preceding outpatient surgery.

Multiple Procedures
- Harvard Pilgrim applies a multiple procedure discount to a specified list of procedure codes.
- When applicable multiple procedures are performed at the same session, the primary procedure is reimbursed at 100% of the allowable rate and all subsequent reimbursable procedures are paid at 50% of the allowable rate. Harvard Pilgrim determines the primary procedure based on the highest allowable rate.
- Surgery/significant procedures will be paid at a maximum count of one per line.

Bilateral surgery
- Bilateral surgeries performed on both sides of the body during the same operative session, or on the same day, are reimbursed at 150% of the fee schedule allowed amount. Claim must be billed on a single service line with CPT and modifier 50 appended.

Device-Dependent Codes
Certain procedures require the use of an implantable device. When billing for these procedures report the CPT/HCPCS code for the device, where applicable, in addition to the surgical procedure code.

In cases where the device was provided at no charge to the facility, or the facility receives a credit from the manufacturer, bill Value Code FD with the device credit amount in the Value Amount field and one of the following condition codes:
- 49 Product Replacement within Product Lifecyle
- 50 Product Replacement for Known Recall of a Product
- 53 Initial placement of a medical device provided as part of a clinical trial or free sample

Harvard Pilgrim will reduce the amount allowed for covered services, when high cost Device Dependent Codes are billed with no material device charges or the device is provided at no cost to the facility.
- This reduction applies but is not limited to cochlear implants, defibrillators, pacemakers, neurostimulators/generators, and spinal infusion pumps.

Other Information
- C Codes — Harvard Pilgrim will accept most C codes only from outpatient facilities and ambulatory surgery centers.

Member Cost-Sharing
Services subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible).

Provider Billing Guidelines and Documentation
Coding[2]

UB-04 Billing

Code	Description	Comments
036X	Operating Room Rev Code	CPT/HCPCS required

Code	Description	Comments
045X	Emergency Room Rev Code	Use to bill all surgical procedures performed in the emergency room.
049X	Ambulatory Surgery Rev Code	CPT/HCPCS required

Surgical Centers Billing on a CMS-1500 Form
- For CMS-1500 or electronic 837P billing only, the modifier SG is required. Modifier SG is not required for services submitted on a UB-04 or electronic 837I.
- Modifier SG is defined as: Ambulatory Surgery Center facility services.
- Absence of the modifier SG may delay the processing of the claim. To facilitate prompt payment, modifier SG is required.
- For CMS-1500 billing or electronic 837P, submit the CPT/HCPCS code that most accurately represents the service provided.

Related Policies
Payment Policies
- Billing Requirements for Outpatient Revenue Codes
- CPT and HCPCS Level II Modifiers
- Dialysis
- Emergency Room
- Hospital Based Clinic
- Non-Covered Services
- Observation Stay
- Physical, Occupational, and Speech Therapy
- Treatment Room

Referral, Notification & Authorization
- Prior Authorization Policy

PUBLICATION HISTORY

07/31/07	original documentation
07/31/08	bilateral billing information added
10/31/08	annual review; edits for clarity
09/15/09	annual review; minor edits for clarity
10/15/10	annual review; added ASC modifier SG billing requirement
10/15/11	annual review; minor edits for clarity
01/01/12	removed First Seniority Freedom information from header
10/15/13	annual review; update to C codes
06/15/14	added *Connecticut Open Access HMO* referral information to Prerequisites
09/15/14	annual review; administrative edits
10/15/15	annual review; updated billing guidelines
10/15/16	annual review; administrative edits
08/15/17	removed "standard" from Harvard Pilgrim Standard Outpatient Facility Fee Schedule in first sentence under policy section
10/15/17	annual review; no changes
01/01/18	updated Open Access Product referral information under Prerequisites
11/01/18	annual review; clarified Policy section to reflect policy applies to the hospitals and ASC's contracted under the standard Harvard Pilgrim Outpatient Facility Fee Schedule based on APC Medicare methodology
11/01/19	annual review; clarified Device-Dependent Codes section; clarified separately reimbursed professional and ancillary services; administrative edit
11/02/20	annual review; administrative edits; updated Provider Billing Guidelines and Documentation
11/01/21	annual review; no changes
11/01/22	annual review; no changes
11/01/23	annual review; updated related policies

11/01/24   annual review; updated related policies

[1]This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

[2]The table may not include all provider claim codes related to the HPHC outpatient facility fee schedule.