Outpatient Facility Fee Schedule

Policy
This policy applies to hospitals and ambulatory surgical centers contracted under the Harvard Pilgrim Outpatient Facility Fee Schedule.

- 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 apply.
(Refer to Referral, Notification and Authorization for more information.)

HMO/POS/PPO

Connecticut Open Access HMO
For the Connecticut Open Access HMO product, no referral is required to see a contracted specialist.

Harvard Pilgrim Reimburses

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, version 5010 - 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, observations, implantable device, most pharmacy and supplies.
- Harvard Pilgrim reimburses the following services separately from the contracted rate:
  - Ancillary services such as laboratory, pathology, radiology.
- 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, bill the device code with a charge of $1.00. 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., co-payment, coinsurance, deductible).

**Provider Billing Guidelines and Documentation**

**Coding**

**UB-04 Billing**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>036X</td>
<td>Operating Room Rev Code</td>
<td>CPT/HCPCS required</td>
</tr>
<tr>
<td>045X</td>
<td>Emergency Room Rev Code</td>
<td>Use to bill all surgical procedures performed in the emergency room.</td>
</tr>
<tr>
<td>049X</td>
<td>Ambulatory Surgery Rev Code</td>
<td>CPT/HCPCS required</td>
</tr>
<tr>
<td>0762</td>
<td>Observation Room Rev Code</td>
<td></td>
</tr>
<tr>
<td>082x–085x, 088x</td>
<td>Dialysis Rev Codes</td>
<td></td>
</tr>
</tbody>
</table>

**Surgical Centers Billing on a CMS 1500 Form**

- For CMS-1500 or electronic 837P, version 5010 billing only, the modifier SG is required. Modifier SG is not required for services submitted on a UB 04 or electronic 837I, version 5010.
- 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, version 5010, submit the CPT/HCPCS code that most accurately represents the service provided.
Related Policies

- Authorization Payment Policy
- Bilateral Services and CPT Modifier 50 Payment Policy
- Billing Requirements for Outpatient Revenue Codes
- Blood Products and Services Payment Policy
- CPT and HCPCS Level II Modifiers Payment Policy
- Dialysis Payment Policy
- Emergency Room Payment Policy
- Injectable and Implantable Outpatient Drugs Payment Policy
- Non-Covered Services Payment Policy
- Notification Policy
- Observation Stay Payment Policy
- Physical, Occupational, and Speech Therapy Payment Policy
- Treatment Room Payment Policy
- Hospital Based Clinic Payment 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

1This policy applies to the products of Harvard Pilgrim Health Care and its affiliates—Harvard Pilgrim Health Care of Connecticut, 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.

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