

Hospital-based Clinic

Policy

Harvard Pilgrim reimburses clinic services rendered in a facility setting when performed by a contracted provider and ordered by the member's PCP for diagnostic, preventive, curative, rehabilitative or educational services to ambulatory patients. Discrete facility charges associated with evaluation and management (E&M) services in the clinic settings are not reimbursed.

Policy Definition

Clinic Services are preventive, diagnostic, therapeutic, rehabilitative, palliative, or educational nonemergency outpatient services that are furnished to ambulatory patients.

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

- A physician's order is required for clinic services.
- Referrals are required for specialist services for HMO and in-network POS members.

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 Reimburses¹

HMO/POS/PPO

Evaluation and Management (E&M) Services, Eye Care, Screening and Assessment Services

Harvard Pilgrim reimburses providers for clinic E&M, eye care, screening and assessment services at a global rate that includes both facility and professional services.

- Payment for clinic services is based upon the contracted professional fee rate for the facility.
 - Facility charges are not separately reimbursable.
- Clinic services are reimbursed solely to the provider (hospital or physician) contracted with Harvard Pilgrim to bill for clinic services.

Non-E&M Services

- Reimbursement is based on Harvard Pilgrim's contracted rate for the procedure code.
- Related charges or services may be denied.

Harvard Pilgrim Does Not Reimburse

HMO/POS/PPO

- Comprehensive pain clinics or pain management programs.
- Handling fees, routine blood draws, special reports or telephone management billed with evaluation and management codes.
- Facility E&M, eye care or screening and assessment charges; these charges are included in the professional fee. The member is not liable for these charges.

Member Cost-Sharing

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

Provider Billing Guidelines and Documentation
Coding²

Code	Description	Comments
0280	Oncology	E&M, eye care, and screening and assessment service codes will be denied when billed.
0510–0515, 0517, 0519, 0520–0523, 0526, 0529	Clinic	UB-04 billing form or electronic 837I, version 5010, bill with appropriate CPT/HCPCS codes; E&M, eye care, and screening and assessment service codes will be denied.
0760-0761	Treatment Room	E&M, eye care, and screening and assessment service codes will be denied when billed.
0770-0771	Preventive Care Services	E&M, eye care, and screening and assessment service codes will be denied when billed.
096X, 097X or– 098X	Professional Fees	Used to bill a global E/M visit (includes facility and professional services).
G0463	Hospital outpatient clinic visit for assessment and management of a patient	Not reimbursed

Other Information

- When billing for the technical and professional components of an E&M service on the UB-04 or electronic 837I version 5010 revenue code 096X, 097X or 098X should be used. A separate billing of the professional component of the E&M service is not expected to be billed.
- Facility fees associated with clinic/outpatient services, as indicated below, must be billed under a clinic revenue code in the 051X or 052X series and will be denied.

99201-99499	92002	92004	92012	92014	G0101
G0181	G0182	G0245	G0246	G0296	G0406
G0407	G0408	G0425	G0426	G0427	G0443
G0445	G0446	G0473	G0506	G0508	G0509

Related Policies
Payment Policies

- Evaluation and Management
- Treatment Room

PUBLICATION HISTORY

09/01/00	original documentation
01/01/02	added detailed clinic services coding
04/01/02	clarified pain clinic reimbursement
04/01/06	updated policy definition
05/31/08	annual review; clarified E&M reimbursement language
10/31/08	annual review; minor edits for clarity
08/15/09	annual review; no changes
09/15/10	annual review; minor edits for clarity
09/15/11	annual review; minor edits for clarity
01/01/12	removed First Seniority Freedom information from header
10/15/12	annual review; no changes
10/15/13	annual review; no changes

PAYMENT POLICIES

01/15/14	annual coding update; added new HCPCS G0463 as non-covered
06/15/14	added <i>Connecticut Open Access HMO</i> referral information to Prerequisites
10/15/14	annual review; no changes
10/15/15	annual review; updated billing instructions
10/15/16	annual review; administrative edits
10/15/17	annual review; no changes
01/01/18	updated Open Access Product referral information under Prerequisites
10/01/18	annual review; added 280, 760-761, 770-771 revenue codes; administrative edits
05/01/19	added eye care, screening and assessment services codes
09/03/19	administrative edits
11/01/19	annual review; no changes
11/01/21	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 clinic services.