Outpatient Clinic Services – Facility

Policy

Mass General Brigham Health Plan reimburses contracted health care providers for covered, medically necessary outpatient diagnostic, preventive, curative, rehabilitative, and education services when performed in a clinic in the acute care hospital outpatient setting.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Coding Provider Payment Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Mass General Brigham Health Plan

Provider Payment Guidelines

Mass General Brigham Health Plan's reimbursement is based on line of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type:

MassHealth and MyCare Family members:
Mass General Brigham Health Plan utilizes MassHealth Acute Outpatient Manual as guidance for its reimbursement methodologies. Providers should consult the MassHealth Acute Outpatient Hospital Manual (AOH)

Commercial and Medicare Advantage members:
Entire guideline applies

Mass General Brigham Health Plan Reimburses

- Professional component of one Evaluation and Management (E/M) code per member, per date of service when performed in a hospital outpatient clinic setting.
- Professional and facility components when:
    - E/M services are performed in an outpatient mental health clinic.
    - Non-E/M services are performed in the outpatient clinic setting.

Mass General Brigham Health Plan Does *Not* Reimburse

- Facility component of the E/M service performed in any outpatient clinic setting, except an outpatient mental health clinic. A separate facility fee will not be made to the hospital or to any other provider.

E/M services billed with a non-clinic revenue code in conjunction with a bill for the clinic professional component of the same service will be subject to post-payment audit and retraction.

Provider Payment Guidelines and Documentation

Please note: provider contracts stipulate which payment method is utilized to process a given provider's claims. Please consult the governing provider contract for detail on which payment method is use for the services described in this PPG.

- **Contracts with outpatient services reimbursed using EAPG or OPPS fee schedule methodologies: reimbursement is dependent upon the HCPCS/CPT codes billed**
- **Contracts with outpatient services reimbursed using PAF: facility fees reimbursed in conjunction with E/M services are subject to retraction.**

Procedure Codes

Note: Code descriptors modified from the AMA CPT for publishing purposes. This list of codes may not be all-inclusive and can and will change from time to time. Inclusion of a code in this document does not imply or guarantee coverage and/or reimbursement.

Code	Descriptor	Comments
99202-99499	E/M codes as defined and described by the American Medical Association	Not reimbursable when billed with Revenue Code 51X for providers whose contract stipulate OPPS fee schedule or EAPG payment method(s).
G0463	Hospital outpatient clinic visit for assessment and management of a patient	Reimbursable only to providers whose contracts stipulate OPPS fee schedule or EAPG payment method(s). Bill with Revenue Codes 510 or 770. Commercial billers: Do not bill a separate professional claim.
510	General Clinic Visit	Facility fees are not reimbursed separately for E/M services delivered in outpatient clinic settings.
511	Chronic pain center	
512	Dental Clinic	
513	Psychiatric clinic	
514	OB/GYN clinic	
515	Pediatric clinic	
516	Urgent Care clinic	E/M services are not reimbursable
517	Family practice clinic	
519	Other clinic	
761	Treatment Room	E/M services will be retracted as non-reimbursable clinic facility component when the same E/M is billed with Revenue Code 983
770	Preventive Services	
983	Professional component – Clinic	E/M services are reimbursed. If the same E/M service is billed separately as a professional claim, it will be denied.

Mass General Brigham Health Plan

Provider Payment Guidelines

Related Documents

General Coding and Billing
Modifiers
Mass General Brigham Health Plan Net Referral and Authorization User Guides
Not Payable Per MassHealth Code Set
Unlisted Code usage requirements

Publication History

Topic: Outpatient Clinic Services - Facility	Owner: Network Management
January 1, 2019	*Original documentation*
	Document restructure; codes, code descriptor and references updated
January 1, 2023	*Document rebrand; updated references*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Plan Insurance Company.