

Payment Policy: Facility Charges for Hospital-Based Outpatient Clinics

Reference Number: CC.PP.059
Last Review Date: 11/2024

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See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

Facility charges for hospital-based outpatient clinics are routinely billed by participating hospitals. In most cases, the facility charge is for the physical room in which service by another provider (typically a physician) is rendered. The hospital is typically not providing in-hospital services such as nursing. In such cases, the facility charge is not for actual hospital services and is not governed by the participation agreement between the health plan and the hospital.

The purpose of this policy is to define payment criteria for facility charges rendered at outpatient hospital clinics to be used in making payment decisions and administering benefits.

Application

- Hospital-based Outpatient Clinics (Revenue Code 510)

Excludes

- Excludes Critical Access Hospitals
- Excludes Safety Net Hospitals

Policy Description

It is the policy of the health plan that facility charges for hospital-based outpatient clinics (revenue code 510) do not represent covered services under the health plan provider participation agreements. As such, the charges are not applicable to be reimbursed under the rate exhibits set forth in such agreements unless specifically addressed.

Health plans that reimburse providers for facility charges are required to compensate providers on the basis of the *reasonable* cost of the care or *reasonable* charge for the services.

Reimbursement

- A. The health plan has determined that additional reimbursement for facility charges for outpatient hospital clinics is not warranted unless determined by state or health plan policy. The health plan will pay all other revenue codes in accordance with the provider participation agreement in place between the health plan and the hospital.
- B. If the hospital can demonstrate the provision of actual hospital services such as those that may be provided in a wound clinic or dialysis clinic or other clinic, the health plan may pay for such services in accordance with the provider participation agreement.
- C. The fact that the health plan has contracted with facilities to reimburse at percentages of billed charges does not mean the health plan must blindly reimburse for all charges, regardless of whether they are reasonable.

PAYMENT POLICY

FACILITY CHARGES FOR HOSPITAL-BASED OUTPATIENT CLINICS

Documentation Requirements

NA

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT/HCPCS Code	Descriptor
510	Clinic – General Classification

Modifier	Descriptor
NA	NA

ICD-10 Codes	Descriptor
NA	NA

Definitions

Outpatient Hospital Clinic

A clinic that is owned and operated by a hospital system and is located either on or off the main hospital grounds.

Critical Access Hospital

Designation given to certain hospitals either located in a rural area or certain hospital providers in urban areas to be treated as rural by the Centers for Medicare and Medicaid Services (CMS). Currently participating Medicare hospitals, hospitals that ceased operation after 11-29-89 and health clinics or centers (as defined by the state) that previously operated as a hospital before being downsized to a clinic or health center.

Safety Net Hospital

Providers that organize and deliver a significant level of healthcare and other health-related services to the uninsured, Medicaid and other vulnerable patients.

Additional Information

When applicable, the health plan encourages providers to be transparent with patients and make them aware that they are entering a part of the main hospital and may be billed accordingly.

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Furthermore (when applicable) hospital outpatient departments not located on the provider’s main campus should provide written notice to the member, before delivery of services, of the amount of the beneficiary’s potential financial liability (for example, copay for the outpatient hospital visit and the physician service).

Related Documents or Resources

NA

References

- Centers for Medicare and Medicaid Services MLN Booklet (August 2017). *Critical Access Hospital, 3-14. ICN 006400 August 2020.*

Revision History	
01/29/2018	Initial Policy Draft
02/05/2018	Revised per S Jones; MHD specification removed
03/14/2018	MO specific references removed for a corp template
05/01/2018	Removed the \$50 reasonable fee, added D) under reimbursements
05/08/2018	Removed sentence about recognizing hospital cost, because fees unwarranted.
09/01/2019	Conducted review
09/01/2020	Conducted review – removed effective date, updated important reminders and copyright dates
09/01/2021	Conducted review – removed product type, updated important reminders and copyright dates
09/01/2022	Conducted annual review, updated policy dates
08/29/2023	Conducted annual review, updated policy dates
11/14/2024	Conducted annual review, updated policy dates

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or

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regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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