REIMBURSEMENT POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Facility Charges for Hospital-Based Outpatient Clinics-OH MP-PY-1600	05/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.
CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject

Facility Charges for Hospital-Based Outpatient Clinics

B. Background

This policy outlines the guidelines for facility charges associated with services provided in hospital-based outpatient clinics. Patients receiving care in these settings may notice a facility charge on their bill, which is distinct from the fees for the specific procedures or treatments. These charges are typically billed using a UB-04 institutional claim form.

C. Definitions

- **CMS-1500** – A standard claim form that professional providers and medical billing professionals use to bill insurance companies for health care services.
- **Facility Charges** – A charge that is part of the overhead cost of a hospital, which supports the location and other services the hospital must provide and are not directly related to the care a patient receives. Also known as a facility fee.
- **Hospital-Based Outpatient Clinics** – An outpatient facility that may or may not be on the hospital grounds, is operating under the ownership or administrative control of the hospital and offers the same or similar services as the hospital.
- **Network Provider** – Healthcare professionals in good standing who have successfully passed a CareSource credentialing or recredentialing program.
- **Participation Agreement** – An agreement between a health plan and providers or hospitals, which includes terms, such as information about compensation, billing, payment, network participation, provider licensing and insurance, provider credentialing, maintenance of records, termination, and state contracting and filing requirements. Health plans compensate providers for covered services rendered to members and compensate hospitals through facility charges under the terms of the agreement.
- **Revenue Code** – A 4-digit number that is used on hospital bills to inform insurance companies either where the patient was when they received treatment, or what type of item a patient may have received as a patient.
- **UB-04** – Claim form used by hospitals and other providers to bill for institutional services. A valid procedure code must accompany a revenue code for it to be accepted by the insurance provider.

D. Policy

I. CareSource does not provide reimbursement for facility charges associated with clinic services rendered by a network provider for any hospital-based outpatient clinics when billed using the UB-04 form. Specifically, facility charges billed with revenue code 510 are not reimbursed. as these charges are not considered covered services under the health plan participation agreements.

II. CareSource will only reimburse for clinic services provided for a member that are rendered on the same day in which the treatment is rendered at the hospital-based outpatient clinic when billed on a CMS-1500 professional claim form.

III. Hospitals are prohibited from seeking reimbursement for facility charges at hospital-based outpatient clinics from CareSource, CareSource members, or CareSource subsidiaries when billed using revenue code 510.

E. Conditions of Coverage

Reimbursement policies are designed to assist providers when submitting claims to CareSource. These policies are routinely updated to promote accurate coding and policy clarification. There proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and office staff are encouraged to use self-service channels to verify members' eligibility. Reimbursement id dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

The following list of revenue codes are provided as a reference and are not reimbursable.

Revenue Code	Description
0510	General

F. Related Policies/Rules

N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	03/12/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	05/01/2025	
Date Archived		

H. References

1. Brocks J. Health plan network provider agreement essentials. LexisNexis. Published April 20, 2019. Accessed November 6, 2024. www.lexisnexis.com
2. Facility fees and how they affect health care prices. Health Care Cost Institute. Accessed November 6, 2024. www.healthcostinstitute.org
3. Professional paper claim form (CMS-1500). Centers for Medicare & Medicaid Services. Accessed November 6, 2024. www.cms.gov
4. What is outpatient facility coding and reimbursement. AAPC. Reviewed December 14, 2023. Accessed November 6, 2024. www.aapc.com