

Commercial Reimbursement Policy	
Subject: Facility Guidelines for Claims Related to Professional Services - Facility	
Policy Number: C-15004	Policy Section: Facilities
Last Approval Date: 11/12/2025	Effective Date: 04/01/2026

Policy

The health plan does not allow professional services when billed on a UB-04 claim form unless provider, state, federal contracts, and/or mandates indicate otherwise.

The services below are required to be billed on a CMS-1500 claim form:

- Evaluation and Management services rendered in an office, professional building, medical office building, clinic, or a space owned by a hospital or an institutional provider, other than the primary structure on the campus of the hospital or institutional provider, or rented by a professional from the hospital or an institutional provider
- Evaluation and Management services rendered within a primary structure of a facility
- Preventive Counseling services rendered in an outpatient setting of a facility

The health plan requires any services not billed on a CMS-1500, as indicated above, append modifiers PN/PO/ER to outpatient claims when applicable:

- Modifier PN must be appended on each claim line for services, procedures and/or surgeries provided at an off-campus location that is not contracted as part of the hospital agreement.
- Modifier PO must be appended on each claim line for services, procedures and/or surgeries provided at any off-campus provider-based outpatient departments that are specifically contracted under the hospital agreement.
- Modifier ER must be appended on each claim line for outpatient hospital services furnished in an off-campus provider-based emergency department.

Revenue codes 960-989 (professional fees) are not allowed for reimbursement when submitted on a UB-04. These professional services should only be billed with the applicable HCPCS code on a CMS-1500 claim form.

The health plan will reimburse the Emergency Room E&M codes (99281 - 99285, G0380 - G0384) when billed under the appropriate revenue codes. Professional services for the Emergency Room must be billed on a CMS-1500 claim form.

Services rendered outside of the primary structure on the campus of a hospital, or an institutional provider shall not be billed or reimbursed on a UB-04 claim form. Services that are rendered outside of the hospital must be billed on a CMS 1500 by the provider rendering the service.

Related Coding

Modifier	Description	Comments
PN	Nonexcepted service provided at an off-campus, outpatient, provider-based department of a hospital	Reimbursed at 40% of the allowable
PO	Excepted service provided at an off-campus, outpatient, provider-based department of a hospital	
ER	Items and services furnished by a provider-based, off-campus emergency department	

Definitions

Evaluation and Management Services	Evaluation and management (E/M) coding is the use of CPT® codes from the range 99202-99499 to represent services provided by a physician or other qualified healthcare professional. As the name E/M indicates, these medical codes apply to visits and services that involve evaluating and managing patient health.
Provider-based off-campus emergency department	Any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements: (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department. (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or (3) During the calendar year immediately preceding the calendar year in which a determination under this section is made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.
General Reimbursement Policy Definitions	

Related Policies and Materials

Clinic Charges - Facility
Place of Service - Professional

References and Research Materials

This policy has been developed through consideration of the following: <ul style="list-style-type: none">• CMS• Optum EncoderPro 2025
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Policy History

11/12/2025	Review approved 11/12/2025 and effective 04/01/2026: added modifiers PN, PO, and ER be billed on outpatient claims not billed on a CMS 1500; updated Related Coding section with modifiers PN, PO, and ER description and reduction; updated Definitions section by adding Provider-based off-campus emergency department
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06/28/2023	Review approved 06/28/2023 and effective 12/01/2023: title updated from Place of Service - Facility; professional services billed under revenue codes 984-989 are nonreimbursable when submitted on a UB-04
04/27/2022	Initial approval 04/27/2022 and effective 10/1/2022: professional services billed under revenue codes 960-983 are nonreimbursable when submitted on a UB-04; preventive counseling CPTs 99401–99404 & 99411 & 99412 when billed in an outpatient setting are nonreimbursable

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving, and we reserve the right to review and update these policies periodically.

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