healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	Hospital Outpatient Clinic Visit – CPT/HCPCS Code G0463		
Policy Number:	PO-RE-153v2		
Effective Date:	01/01/2025	**Last Approval Date:**	10/7/2026

I. Policy Description

This policy outlines the billing, coding, and reimbursement guidelines for hospital clinic visits billed under HCPCS code G0463. The purpose is to ensure accurate claims submissions, compliance documentation, and the appropriate reimbursement in accordance with Center for Medicare and Medicaid Services (CMS) guidelines, and Healthfirst payment policy.

G0463 represents a hospital facility charge for outpatient visits involving assessment and management of patients. It does not include professional services which are billed separately by practitioners using the standard CPT and Evaluation and Management (E&M) codes.

The information below applies to the following lines of business:

- Child Health Plus (CHP)
- Medicaid Managed Care (MMC)
- Medicare Advantage
- Medicare PPO
- Personal Wellness Plan (HARP)
- Essential Plan (EP)
- Managed Long Term Care Plan (MLTCP – Senior Health Partners)
- Medicaid Advantage Plus/MAP (CompleteCare)
- Qualified Health Plan (QHP)

Reimbursement Guidelines

This policy only applies to Hospital Outpatient facilities and provider-based clinics billed under the Outpatient Prospective Payment System (OPPS).

1. Facility vs Professional Billing

Component	Code(s) Used	Description
Facility	HCPSC G0463	For Outpatient clinic visits (facility cost only)
Professional Services	CPT 99202-99215	For physician/practitioner services billed separately

2. Revenue Codes for Reimbursement

G0463 is reimbursable only when billed with the following revenue codes:

- Clinic: 0510–0517, 0519, 0520
- ER/Urgent Care: 0456
- Treatment Room: 0761

3. Claim Submission Requirements

Hospitals and provider-based departments must submit billing for code G0463 on the UB-04 claim form (or electronic 837I).

- Each claim must include:
  - A valid revenue code
  - Modifier PO or PN with HCPCS code G0463
  - A valid ICD-10-CM diagnosis code that supports medical necessity

4. Modifier Guidelines

Modifier	Description	Payment
PO	Used for services at excepted off-campus hospital clinics	Full OPPS rate
PN	Used for services at non-excepted off-campus clinics	Reduced payment

- Only one modifier (PO *or* PN) is allowed per claim line.
- Do not use Modifier PO for:
  - Remote or satellite hospital locations
  - Emergency departments
  - Critical Access Hospitals (CAHs)
  - Non-provider-based sites

5. Coding and Documentation

- Documentation must clearly support the assessment and management rendered.
- Include details:
  - Chronic conditions review
  - Medication management,
  - Care coordination (if applicable)
  - Patient History
- Coders must review CMS OPPS status indicators to determine whether G0463 is separately payable or packaged

General Reimbursement Requirements

1. Reimbursement for hospital clinic visits for assessment and management will be determined based on the provider's scope of services and the reimbursement rates outlined in the provider's contract with Healthfirst.
2. Claims may be denied or underpaid if the following occur:

- Use of invalid revenue codes
- Missing or incorrect modifier (PO or PN)
- Duplicate billing of G0463 and CPT E&M code for same visit
- Inadequate documentation

3. If the line of business (LOB) is not mentioned in this policy, the services are not covered and not eligible for reimbursement.

4. This policy is a provider resource for understanding Healthfirst's reimbursement guidelines. It does not guarantee coverage or payment. Final reimbursement decisions depend on benefit coverage, state/federal mandates, medical necessity, and provider contract.

5. Claims submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. *Refer to: Healthfirst Provider Manual Subsection 17.6, "Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process" in this section.*

For any questions or further clarification regarding this policy, providers are encouraged to reach out to their designated contact within our organization

I. Applicable Codes

Code	Description	Comment
G0463	Hospital outpatient clinic visits for assessment and management a patient	

II. Definitions

Term	Meaning
CPT	Current Procedural Terminology
E&M	Evaluation and Management
HCPCS	Healthcare Common Procedure Coding System
OPPS	Outpatient Prospective Payment System

III. Related Policies

Policy Number	Policy Description
N/A	N/A

Current Procedural Terminology © American Medical Association. All rights reserved.

Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

IV. Reference Materials

Hospital Outpatient Prospective Payment System (OPPS)
MM13488 - Hospital Outpatient Prospective Payment System: January 2024 Update
MM13031 - Hospital Outpatient Prospective Payment System: January 2023 Update

V. Revision History

Revision Date	Summary of Changes
10/7/2026	**Annual Review** Policy reviewed as part of the annual review process; no substantive changes to policy intent.
9/4/2026	**Annual Review:** Policy reviewed as part of the annual review process; no substantive changes to policy intent.

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for the services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.