

Subject:	Outpatient Facility and Professional Claim Reimbursement – Lesser-of Methodology		
Policy Number:	PO-RE-165v1		
Effective Date:	01/01/2026	Last Approval Date:	03/16/2026

I. Policy Description

This policy outlines Healthfirst’s standard reimbursement methodology for outpatient facilities and professional claims. Healthfirst applies a "lesser-of" reimbursement provision at the individual charge line level of submitted claims. This methodology is applied across standard line-item billing, as well as OPSS (Outpatient Prospective Payment System) and APG (Ambulatory Patient Groups) reimbursement structures.

Under this policy, reimbursement is limited to the lower of:

- The provider’s billed charge for the specific line item; or
- The allowed amount as determined by the applicable Healthfirst provider contract, internal fee schedule, or external benchmark (e.g., contracted fee schedule, bundled rate, per diem rate, global case rate, OPSS, or APG).

Where a provider agreement is silent on how pricing is to be applied under these methodologies, Healthfirst will default to applying the lesser-of logic at the line level. This ensures compliance with regulatory standards and promotes financial integrity by preventing payment in excess of submitted charges.

The information below applies to the following lines of business:

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

Policy Scope

Healthfirst shall reimburse outpatient facility and professional services in accordance with the following Methodology:

Reimbursement per service line = Lesser of (Billed Charge, Allowed Amount)

This methodology applies to the following reimbursement models:

- Line-item pricing (contracted or fee schedule)
- Outpatient Prospective Payment System (OPPS) / APC logic
- Ambulatory Patient Groups (APG) logic
- Bundled payments
- Per diem rates
- Global case rates

Where applicable, reimbursement may be calculated at the line level or at the encounter level, but in all cases the final reimbursement will not exceed the provider's billed charges.

When a provider agreement includes specific language regarding the application of lesser-of logic under any of these methodologies, such language shall prevail. However, in the absence of explicit contract provisions, Healthfirst will apply the lesser-of rule by default.

Reimbursement and Billing Guidelines

1. Claim Submission Requirements

- Claims must be submitted using industry-standard formats:
 - CMS-1500 for professional services.
 - UB-04 for facility-based outpatient services.
- Each line must include valid CPT/HCPCS codes, revenue codes (for facilities), applicable modifiers, units of service, and corresponding billed charges.
- For bundled or case rate claims, appropriate encounter-level billing rules must be followed.

2. Reimbursement Methodology

Healthfirst will determine the allowed amount for each individual claim line using the applicable methodology:

Reimbursement Type	Calculation Basis	Application of Lesser-of
Line-item FFS	CPT/HCPCS code-specific fee schedule	Per line
OPPS/APC	CMS APC logic	Per line
APG	State-defined APG weights and rates	Per line

Reimbursement Type	Calculation Basis	Application of Lesser-of
Bundled Payment	Contracted case rate or procedure bundle	Per bundle or line
Per Diem	Contracted daily rate	Per diem or line
Global Case Rate	Contracted rate for defined episode of care	Per case or line

Reimbursed Amount = Lesser of (Provider's billed charge, Allowed amount under methodology)

3. Claim Examples

Example 1: Line-Level – Allowed Amount Greater Than Billed Charge

Line	CPT Code	Description	Billed Charge	Allowed Amount	Reimbursed Amount
1	66984	Cataract Surgery (APC 5521)	\$800	\$1,050	\$800

Reimbursement is limited to the billed charge.

Example 2: Line-Level – Allowed Amount Less Than Billed Charge

Line	CPT Code	Description	Billed Charge	Allowed Amount	Reimbursed Amount
1	71045	Chest X-ray	\$150	\$100	\$100

Reimbursement is limited to the allowed amount.

Example 3: APG/OPPS Logic – Billed Below APG Allowance

Line	CPT Code	Description	Billed Charge	APG Allowed Amount	Reimbursed Amount
1	99385	Preventive Visit	\$85	\$120	\$85

APG/OPPS pricing yields a higher rate, but reimbursement is capped at the billed charge.

Example 4: Bundled Payment

Procedure Bundle	Description	Billed Charge	APG Allowed Amount	Reimbursed Amount
Colonoscopy	Facility + Ancillaries	\$1200	\$1500	\$1200

Example 5: Per Diem

Day	Description	Billed Charge	APG Allowed Amount	Reimbursed Amount
1	Observation Care	\$900	\$1000	\$900

Limitation and Exclusions

- Behavioral health and addiction services are excluded from this policy. Reimbursement for behavioral health and addiction services are governed by applicable state regulations, mandated payment methodologies, and/or specific provider contract terms.
- This policy applies only to outpatient facility and professional services. Inpatient services are excluded and may follow separate reimbursement methodologies as defined in the applicable provider contract, payment methodology, or other Healthfirst reimbursement policies.
- This policy does not apply to services for which reimbursement rates are mandated by federal or state law, regulation, or regulatory authority. In such cases, Healthfirst will reimburse providers in accordance with the applicable regulatory requirements, program guidance, or mandated rate schedules.
- Where a provider agreement includes specific reimbursement terms that differ from this policy, those terms will govern. If the contract is silent, Healthfirst will apply the lesser-of logic by default, including under bundled payment, per diem, and global case rate models.

Adjudication and Appeal Process

1. Reimbursement for services 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 submitted by providers that do not adhere to this policy will be denied or rejected. It is the responsibility of the provider to ensure claims are coded accurately.
3. This policy applies only to the line(s) of business (LOB) identified at the beginning of the policy and does not apply to other LOBs. For policies applicable to other lines of business, please visit www.hfproviders.org.
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

II. Applicable Codes

Code	Description	Comment

III. Definitions

Term	Meaning

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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

V. Reference Materials

VI. Revision History

Revision Date	Summary of Changes

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.