Commercial Reimbursement Policy

Subject: **Outpatient Facility Revenue Code Billing Requirements - Facility**	
Policy Number: **C-18003**	Policy Section: **Facilities**
Last Approval Date: **04/01/2024**	Effective Date: **07/01/2024**

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 an Anthem Blue Cross (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use 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, Anthem 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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, Anthem will publish the most current policy to the website.

Policy

The health plan requires facilities to report current and valid CPT or HCPCS codes with all Revenue Codes, as specified in the National Uniform Billing Committee (NUBC) requirements, on outpatient facility claims unless provider, state, or federal contracts and/or requirements indicate otherwise.

The facility shall also report current and valid CPT or HCPCS codes for the remaining revenue codes, when and if appropriate CPT or HCPCS codes are available. The facility shall bill the applicable modifiers on outpatient facility claims.

Related Coding

NUBC requirements apply

Policy History

04/01/2024	Review approved 04/01/2024 and effective 07/01/2024: updated Definitions section to include Modifiers
09/14/2020	Review approved: added Outpatient to policy title, updated References and Research Materials and Related Policies and Materials sections
09/01/2019	New policy template: removed description section and added definition section
08/03/2018	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- American Academy of Professional Coders
- CMS
- National Uniform Billing Committee (NUBC)

Definitions

Modifiers	Two-digit code that provides additional information about the medical procedure, service, or supply involved without changing the meaning of the code.
National Uniform Billing Committee (NUBC)	Develop and maintain a single billing form and standard data set to be used nationwide by institutional, private, and public providers and payers for handling health care claims.
Revenue Code	Unique 4-digit numbers that are descriptions and dollar amounts charged for hospital services provided to a patient.
General Reimbursement Policy Definitions	

Related Policies and Materials

Place of Service - Facility

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.