# Commercial Reimbursement Policy

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| Subject: **Overhead Expense for Office Based Surgery and Diagnostic Testing** | |
| Policy Number: **C-13002** | Policy Section: **Surgery** |
| Last Approval Date: **07/20/2022** | Effective Date: **07/20/2022** |

## Disclaimer

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Anthem 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. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Our policies apply to both participating and nonparticipating professional and facilities as indicated.

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
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed

Anthem's reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, State, Federal or Centers for Medicare and Medicaid Services (CMS) contracts and/or requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Anthem strives to minimize these variations.

## Policy

Anthem allows reimbursement to a surgeon for office based surgery which includes all expenses involved in the performance of the surgery unless provider contract language or state or federal contracts and/or mandates indicate otherwise.

Anthem does not separately or directly reimburse any other provider or vendor that furnishes any items for or during performance of the office based surgery unless other provider or vendor has a contract with the Health Plan. The office based fee allowance that

is paid to the surgeon who performs the office based surgery is inclusive of all necessary overhead expenses.

Anthem incorporates office based site of service differentials in its fee schedule methodologies for most routinely and commonly performed office based surgeries. Consequently, only the surgeon who performs the surgery may submit claims to the Health Plan for office based surgery and associated expenses.

In addition, the reimbursement for office based diagnostic testing includes all expenses involved in the performance of the test, including supplies, overhead, and equipment utilized to render such tests.

## Related Coding

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| Standard Correct Coding applies |

## Exemptions

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| There are no exemptions to this policy. |

## Policy History

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| 07/20/2022 | Biennial review approved: minor language updates |
| 05/27/2020 | Biennial review approved: policy language updated; policy statement updated |
| 06/01/2019 | New policy template: removed description section and added definition section |
| 04/06/2018 | Biennial review approved: Policy language updated to remove example |
| 05/03/2016 | Annual review: No substantial changes (wordsmithing such as adding the word “the” in Front of Health Plan to be consistent with our other policies) |
| 05/05/2015 | Annual review approved: No changes to the policy or the languag |
| 04/01/2014 | Annual review approved: Updated policy language in the description section |
| 05/02/2013 | Minor revision: Correct typo; Space added to second to last line c policy section between CPT 95800-95811 is inclusive |
| 04/02/2013 | Initial policy approval and effective date |

## References and Research Materials

This policy has been developed through consideration of the following:

- Centers for Medicare and Medicaid Services (CMS)

## Definitions

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| Site of Service Differential | Difference in reimbursement, based on where the professional service is performed. Some professional services may be provided either in a facility or a non-facility. When a professional service is provided in a facility, the costs of the clinical personnel, equipment, and supplies are incurred by the facility, not the physician practice. For this reason, reimbursement for professional services provided in a facility may be lower than if the services were performed in a non-facility setting. |
| General Reimbursement Policy Definitions | |

## Related Policies and Materials

None

**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.