Commercial Reimbursement Policy

Subject: **Facility Guidelines for Claims Related to Professional Services - Facility**	
Policy Number: **C-15004**	Policy Section: **Facilities**
Last Approval Date: **06/28/2023**	Effective Date: **12/01/2023**

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 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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, we will publish the most current policy to the website.

Policy

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

The below services 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

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.

Facility Charges for E&M services provided in an Emergency Room and billed with Emergency Room Revenue codes do not apply to the guidelines listed above. 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

Standard correct coding applies

Policy History

06/28/2023	Review approved 06/28/2023 and effective 12/01/2023: title updated from Place of Service - Facility to Facility Guidelines for Claims Related to Professional Services – 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

References and Research Materials

This policy has been developed through consideration of the following:
- American Academy of Professional Coders
- CMS
- Optum EncoderPro 2023

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.

Related Policies and Materials

Clinic Charges - Facility
Office Place of Service - Professional
Place of Service - Professional

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.