Commercial Reimbursement Policy

Subject: **Clinic Charges - Facility**	
Policy Number: **C-14002**	Policy Section: **Facilities**
Last Approval Date: **07/07/2023**	Effective Date: **07/07/2023**

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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 will not allow reimbursement for clinic services when they are rendered to a covered individual at any clinic that is owned, operated, or controlled by a facility or health system when billed on a UB-04 claim form; unless provider, state, or federal contracts and/or mandates indicate otherwise.

The facility or health system agrees that it will seek reimbursement for any claimed technical or overhead component of the clinic charges only from such professional provider, and not from any Elevance Health Plan, subsidiary, or covered individual.
Clinic services must be billed on a CMS-1500 claim form if rendered in:

- An office
- A professional building
- A medical office building
- A free-standing clinic
- Any space (including the primary structure located on the campus of the facility) that is:
    - owned by a hospital, other institutional provider, or health system; or
    - rented by a professional from the hospital, institution, or health-system provider.

Such services are not reimbursable if billed on a UB-04 claim form.

Facility providers should not bill the Health Plan for off-campus clinic charges for any technical component or overhead expenses of a covered service, including use of the space the professional services are provided in.

The professional provider should be instructed to bill place of service “office” when these services are essentially office visits and the hospital, institution, or health system should seek reimbursement from the professional provider. In addition, the covered individual will not be responsible for such clinic charges.

Related Coding

Code	Description
051X	Clinic
0510	General Classification
0511	Chronic Pain Center
0512	Dental Clinic
0513	Psychiatric Clinic
0514	OB/GYN Clinic
0515	Pediatric Clinic
0516	Urgent Care Clinic
0517	Family Practice Clinic
0519	Other Clinic
052X	Freestanding Clinic
0520	General Classification
0521	Clinic Visit by Member to Rural Health Clinic RHC/FQHC
0522	Home Visit by Rural Health Home RHC/FQHC Practitioner
0523	Family Practice Clinic
0526	Urgent Care Clinic (a)
0527	Visiting Nurse Service(s) to a Member's Home when in a Home Health Shortage Area

0528	Visit by RHC/FQHC Practitioner to Other non-RHC/FQHC Site (e.g., Scene of Accident)
0529	Other Freestanding Clinic

Policy History

07/07/2023	Review approved and effective: added language to clarify rendered services billed on CMS-1500 claim form
12/01/2020	Review approved: updated related coding section with revenue codes 051X-0529; updated related policies and materials section
04/22/2020	Review approved
06/01/2019	Revised: removed description section and added definition section
07/13/2018	Review approved: added language
03/11/2014	Initial approval 03/11/2014 and effective 08/12/2014

References and Research Materials

This policy has been developed through consideration of the following:

- Business Decision
- CMS

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Office Place of Service – Professional
Outpatient Facility Revenue Code Billing Requirements – Facility
Place of Service – Facility
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.