Commercial Reimbursement Policy

Subject: **Office Place of Service**	
Policy Number: **C-19004**	Policy Section: **Coding**
Last Approval Date: **03/07/2017**	Effective Date: **03/07/2017**

Disclaimer

These 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 a member's Anthem Blue Cross (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. Unless otherwise noted within the policy, our policies apply to both participating and non-participating providers and facilities. This reimbursement policy also applies to Employer Group Retiree Medicare Advantage programs.
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These policies may be superseded by provider or state contract language, or state, federal requirements or mandates. 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. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan does not reimburse for separate facility fees billed in conjunction with services rendered by professional providers/private practices in an office place of service as defined in this policy. A facility fee is defined as a separate bill submitted by a facility for facility services provided as part of a professional provider's/private practice's service in an office place of service as defined in this policy. Reimbursement for such facility fees is considered included in the reimbursement to the professional provider/private practice.

All procedures and/or services performed by a private professional provider/private practice group in an office POS as defined in this policy will only be eligible for reimbursement when reported on a Form CMS-1500 with an office place of service (POS code 11).

The Health Plan does not recognize Provider Based Clinics (PBCs), as defined by the Centers for Medicare & Medicaid Services (CMS), as an extension of the hospital. Therefore, when the location's focus is seeing patients from the community on a daily basis, the Health Plan considers the services provided in the PBC to be provided in an office.

The Health plan does not recognize ownership of a professional provider/private practice by a hospital or facility, or use of a hospital or facility's tax identification number for claims submission on behalf of the provider/private practice, as a hospital or facility provider, when the setting is office based. Therefore, when this type of relationship exists, the place of service where services are provided is **not** considered by the Health Plan to be a hospital or facility.

The Health Plan defines an office place of service (POS) as a location outside of a hospital or facility wherein the professional provider/private practice may or may not own equipment, compensate staff, or hold responsibility for all overhead expenses. Additionally, the physical site location **does not** include state licensed inpatient beds, a

state licensed emergency room or emergency department, nor provide 24 hour per day seven days a week onsite continuous physician/ other qualified health care professional and nursing services for diagnosis and treatment of patients. The physical site location also **does not** have licensure and accreditation (either Joint Commission or Accreditation Association for Ambulatory Health Care (AAAHC) certification) as an Ambulatory Surgery Center.

In addition, the Health Plan defines an office setting as one that is located **within** a hospital or facility, a professional building attached to and owned by a hospital or facility, or an offsite professional building owned by a hospital or facility when one or more of the following conditions is present:

- Office space is rented by or there is some agreement between the professional provider/private practice that operates under a separate [tax identification number or] National Provider Identifier (NPI), and the hospital or facility.
- The location is in a separately identifiable part of the hospital or facility and used solely as the professional provider's/private practice's office regardless of the state's licensing or certification of certain areas within the hospital or facility as a department of the hospital (e.g., orthopedic clinic, pediatric clinic).
- When equipment is located in rented space within the hospital or facility's "four walls" then the services (e.g., radiology services, electrocardiograms) are considered to be provided in an office setting regardless of who owns the equipment.
- A free standing or off campus location owned by a hospital, facility, or health system that allows for separate offices is considered an office place of service and services provided in this type of setting are considered to be provided in an office.

Related Coding

Standard correct coding applies.

Policy History

09/01/2019	New policy template; removed description section and added definition section
08/01/2017	Policy was adopted by New Hampshire and Ohio
03/07/2017	Annual Review: Added disclaimer language
12/01/2016	Policy was adopted by Connecticut
10/01/2016	Policy adopted by California
06/01/2016	Policy adopted by New York
03/01/2016	Annual Review: Added "other qualified health care provider" in addition to "physician" in section 1 when referring to providers
06/01/2015	Policy was adopted by Georgia
02/03/2015	Revised based on implementation: 1) The first revision is to add "professional" we referring to the provider or practice 2) Under bullet 2a, to bracket tax id number based on the fact that separate providers will always have a separate NPI but may share the same tax id 3) The next update add bullet #5 which will include defining a facility bill and that the facility fees are considered included in the professional reimbursement
08/05/2014	Annual review: No criteria change; only adopted by two states: IN and KY
08/06/2013	New policy approved and effective date

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association (AMA) Current Procedural Terminology (CPT®) Professional Edition 2017

Definitions

Office Place of Service	"Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis."

Related Policies and Materials

None

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.