Commercial Reimbursement Policy

Subject: **Scope of License - Professional**	
Policy Number: **C-17007**	Policy Section: **Administration**
Last Approval Date: **05/16/2022**	Effective Date: **05/16/2022**

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 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 non-participating professionals 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

These policies may be superseded by provider or state contract language, or state, federal requirements or mandates.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

Anthem allows reimbursement for the performance of a covered service or procedure that is within the provider's scope of license.

A non-physician provider must:

- Satisfy the state and federal requirements for the performance of such service or procedure
- Be licensed to perform the particular service or procedure by the state in which the provider practices
- Perform the service and procedure legally authorized to provide under the professional license

Services and procedures performed outside of the non-physician provider's scope of license may not be eligible for reimbursement.

Related Coding

Standard Correct Coding applies

Policy History

05/16/2022	Biennial review approved: minor administrative update
04/21/2020	Biennial review: policy language condensed
06/01/2019	Policy template updated; added definitions section and related coding table
10/19/2017	Initial policy approval 10/19/2017 and effective 03/01/18

References and Research Materials

This policy has been developed through consideration of the following:

- Centers for Medicare and Medicaid Services (CMS)

Definitions

Scope of License	Services and procedures a provider is allowed to perform. Scope of License is determined by: • state licensure laws and advisory opinions • state licensing board rules, advisory opinions and other guidance • federal laws, advisory opinions and other guidance
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.