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 Blue Cross and Blue Shield (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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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

The Health Plan 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

Exemptions

Maine	Anthem Blue Cross and Blue Shield (Anthem) allows: • Professional services with revenue code 964 • Professional services billed under revenue codes 984-989 when submitted on a UB-04 due to delayed implementation
Wisconsin	Anthem Blue Cross and Blue Shield (Anthem) allows: E/M office visit codes to be billed with revenue code 456

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	• Review approved 04/27/2022 and effective 10/01/2022; professional services billed under revenue codes 960-983 are nonreimbursable when submitted on a UB-04; Maine exemption added; preventive counseling CPTs 99401 – 99404 & 99411 & 99412 when billed in an outpatient setting are nonreimbursable *(see update below)*; Maine exemption added. Title renamed to Place of Service – Facility from Place of Service Evaluation and Management Services – Facility; Wisconsin exemption added to allow E/M office visit codes to be billed with Revenue code 456; Kentucky and Wisconsin exemptions removed to apply the policy • Review approved 08/01/2022 and effective 11/02/2022: Maine exemption updated to apply the policy and allow professional services with revenue code 964. • Review approved 10/01/2022 and effective 01/01/2023: Connecticut exemption removed to apply the policy. • Review approved 11/01/2022 and effective 02/01/2023: Missouri exemption removed to apply the policy; Colorado, Georgia, Kentucky, Indiana, Maine, Nevada, New Hampshire, New York, Ohio, Wisconsin received a corrected communication to reflect accurate codes for preventive counseling CPTs 99401 – 99404 (not 99406-99409) & 99411 & 99412 when billed in an outpatient setting are nonreimbursable.
12/09/2020	Review approved: updated Related Coding section with accompanying review codes, and Related Policies and Materials section. Removed exemptions for Georgia and Indiana effective 06/01/2021.
06/01/2019	Policy template updated; related coding and definition section added. Market exemptions added: Connecticut, Georgia, Kentucky, Indiana, Missouri, and Wisconsin
01/01/2016	Policy approved and effective for Colorado, Maine, New Hampshire, Nevada, and Ohio
09/16/2015	Initial approval and effective date

References and Research Materials

This policy has been developed through consideration of the following:

- 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

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.