Massachusetts | Commercial

Commercial Reimbursement Policy

Subject: **Office Place of Service**	
Policy Number: **C-13004**	Policy Section: **Coding**
Last Approval Date: **03/07/2017**	Effective Date: **03/07/2017**

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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.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

Wellpoint 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).

Wellpoint 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, Wellpoint considers the services provided in the PBC to be provided in an office.

Wellpoint 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 Wellpoint to be a hospital or facility.

Wellpoint 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, Wellpoint 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

TBD	New policy template; removed description section and added definition section
03/07/2017	Annual Review: Added disclaimer language
03/01/2016	Annual Review: Added "other qualified health care provider" in addition to "physician" in section 1 when referring to providers
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:

- CMS
- 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.”
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.