COMPLIANCE ALERT

TO: Compliance Alert Distribution List
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SUBJECT: CMS Clarifies Place of Service Instructions - Revised

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A recent Centers for Medicare and Medicaid Services (CMS) transmittal$^{1}$ clarified instructions on reporting Place of Service (POS) codes on claims. While CMS currently maintains the National POS code set, it is used by all other public and private health insurers, including Medicaid. Proper POS code submission has been the focus of audits performed by Medicare Recovery Audit Contractors and the U.S. Department of Health and Human Services Office of the Inspector General.

I. General Instructions for Reporting the POS

In general, the POS code reflects the actual location where the patient received the face-to-face service. The POS determines whether a service will be paid at a facility or nonfacility rate. A facility payment rate is lower than a nonfacility payment rate. The POS code also determines whether a diagnostic test can be paid at the global rate which includes both the Professional Component (PC) and Technical Components (TC) of the test. There are two exceptions to this general rule which are elaborated upon below.

II. Exceptions

A. Special Considerations for Inpatient Hospital (POS code 21)

When a physician/practitioner provides services to a patient who is an inpatient of a hospital, then the appropriate hospital POS code 21 (inpatient hospital) would be reported, regardless of where the face-to-face patient encounter occurs. The facility rate will be paid regardless of where the face-to-face encounter with the patient occurred.

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$^{1}$ CMS Transmittal 2407, Change Request 7631, February 3, 2012
This exception may impact professional billing if a registered inpatient is transported to a physician-based clinic setting for particular services. This should only occur when specialized equipment/instrumentation is available in a physician-based clinic that is not available in the hospital (e.g., dental chair).

The visit code selected must correspond with the POS code. So if an inpatient hospital patient was transported to a physician-based clinic for particular services, an office or other outpatient visit code (99204-99215) could not be reported as the office visit code would not correspond with the inpatient POS code. In this case, The E&M visit code would need to be billed as either a subsequent hospital visit (CPT® codes 99231-99233) or an initial hospital care visit (CPT® codes 99221-99223). The E&M Documentation Guidelines for initial or subsequent hospital visits would be applicable instead of those for office visits. If the visit code does not correspond with the POS code, the Medicare contractor will return the claim as unprocessable.

Globally billed diagnostic studies (those which combine both the PC and TC fees into a single charge), when performed in the physician-based clinic will either be denied due to the location of service when billed with a hospital POS code (21 for inpatient or 22 for outpatient) or downcoded to the PC only. This is because most payers do not reimburse for the technical component of a service when rendered in a hospital location because the equipment and technical staff expense are normally allocated to the hospital.

B. Special Considerations for Outpatient Hospital (POS 19 and POS 22)

Physicians/practitioners who furnish services to a hospital outpatient, including in a hospital outpatient department or under arrangements to a hospital shall use either POS 19 (off-campus outpatient hospital) or POS 22 (on-campus outpatient hospital).

NOTE: Physicians/practitioners who perform services in a hospital outpatient department shall use either POS 19 or POS 22 unless the service is performed in separate office space the physician maintains in the hospital (e.g., clinic space is leased from the hospital) or on the hospital campus and that physician office space is not considered a provider-based department of the hospital.

III. Instructions for the Professional Component (PC) and Technical Component (TC) of Diagnostic Tests

At times, the PC and TC of diagnostic tests are furnished in different settings. As a general policy, the POS code assigned by the physician/practitioner for the PC of a diagnostic test (the interpretation) shall be the setting in which the patient received the TC of the test.

For purposes of determining the appropriate payment locality, CMS requires that the address and ZIP code where the physician performed the PC be reported on the claim. As such, any physicians performing interpretations from their homes must provide an address so the practice plan can report this in the appropriate field on the claim. This is the case even if the physician is viewing the images/tracings/studies through a Virtual Private Network that links to an on-campus computer network.

Example: Patient receives an MRI at Shands-Jacksonville Medical Center and is registered as a hospital outpatient. The physician furnishes the PC of the MRI from his/her home via a VPN.
POS code 22 (on-campus outpatient hospital) would be reported on the physician claim for the PC as this is where the TC of the study was performed. The physician’s address and ZIP code for his home would be reported on the claim so the appropriate payment locality can be determined.

Billing globally for services that are split into PC and TC components is only possible when the TC and the physician who provides the PC of the diagnostic service are furnished by the same physician. Different specialty group practices are not considered the same physician. This means if the TC is performed by one specialty group (e.g. Orthopaedics performs an x-ray of the patient’s foot in a physician-based Orthopaedic clinic) and the interpretation is performed by another specialty group (e.g., Radiology performs a formal interpretive report from their administrative space in the hospital), that the service may not be billed globally by the physician group performing the TC (in this example, Orthopaedics).

These arrangements can be very complicated as the tests may be subject to the “Anti-Markup Payment Limitation.” Those departments who wish to bill globally for diagnostic tests in which the separate components are performed by different specialty groups should contact the Office of Compliance for further guidance specific to their situation.

IV. Labs

An independent laboratory drawing a sample in its laboratory reports POS 81 (Independent Laboratory) as the location of service. If an independent laboratory bills for a test on a sample drawn on a hospital inpatient, POS 21 (Inpatient Hospital) would be reported. Likewise, if an independent laboratory bills for a test on a sample drawn on a hospital outpatient, POS 19 or POS 22 would be reported.

The Office of Compliance advises each medical department to develop a mechanism for identifying hospital patients treated in physician-based clinics so the correct POS code and corresponding CPT® code may be reported. The medical department may also need to seek an arrangement with the hospital to offset reimbursement reductions for treatment of hospital patients.

Because the POS code application may impact procedure code selection and medical record documentation, please share this information with faculty, residents, fellows, non-physician practitioners and applicable billing staff. Feel free to contact me at 244-2158 if you have any questions.

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