

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



News Flash – Existing regulations at 42 CFR 424.510(e)(1)(2) require that at the time of enrollment, enrollment change request or revalidation, providers and suppliers that expect to receive payment from Medicare for services provided must also agree to receive Medicare payments through Electronic Funds Transfer (EFT). Section 1104 of the Affordable Care Act further expands Section 1862 (a) of the Social Security Act by mandating federal payments to providers and suppliers only by electronic means. As part of Medicare's revalidation efforts, all suppliers and providers who are not currently receiving EFT payments will be identified, and required to submit the CMS 588 EFT form with the Provider Enrollment Revalidation application. For more information about provider enrollment revalidation, review the Medicare Learning Network's [Special Edition Article #SE1126](#), titled "Further Details on the Revalidation of Provider Enrollment Information."

MLN Matters® Number: MM7631 **Revised**

Related Change Request (CR) #: 7631

Related CR Release Date: September 28, 2012

Effective Date: April 1, 2013

Related CR Transmittal #:R2561CP

Implementation Date: April 1, 2013

Revised and Clarified Place of Service (POS) Coding Instructions

Note: This article was revised on October 5, 2012 to add POS code 26 (Military Treatment Facility) to the list of facilities rate settings on page 4. It was previously revised on October 4, 2012 to reflect a revised CR7631 issued on September 28, 2012. A section has been added to this article beginning on page 8 regarding global services. Clarification has been added to the discussions regarding services for registered inpatients and for services in hospital outpatient departments. The effective and implementation dates have been revised. In addition, the CR release date, transmittal number, and the Web address for accessing CR7631 were revised. Clarification on the POS for pathology services and independent laboratories will be provided through another CR. All other information is the same.

Provider Types Affected

This article is for physicians, providers, and suppliers billing Medicare contractors (carriers and Medicare Administrative Contractors (A/B MACs)) for services paid for under the Medicare Physician

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Fee Schedule (MPFS). This article also applies to certain services provided by independent laboratories.

What You Need to Know

This article is based on Change Request (CR) 7631. It revises and clarifies national policy for POS code assignment. Instructions are provided in CR7631 regarding the assignment of POS for all services paid under the MPFS and for certain services provided by independent laboratories. In addition to establishing a national policy for the correct assignment of POS codes, instructions are provided for the interpretation of Professional Component (PC) and the Technical Component (TC) of diagnostic tests. Please make sure your billing staff is aware of these changes.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction includes a POS code from the POS code set maintained by the Centers for Medicare & Medicaid Services (CMS). Under Medicare, the correct POS code assignment is also required on the paper CMS 1500 Claim Form (or its electronic equivalent). While CMS currently maintains the National POS code set, it is used by all other public and private health insurers, including Medicaid.

At the time a POS code is developed, CMS determines whether a MPFS facility or non-facility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the MPFS rate designated for each POS code. Under the MPFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries. While Medicare contractors cannot create new POS codes, they are instructed to develop local policies that develop or clarify POS setting definitions in situations where national POS policy is lacking or unclear.

The importance of this national policy is underscored by consistent findings, in annual and/or biennial reports from Calendar Year (CY) 2002 through CY 2007, by the Office of the Inspector General (OIG) that physicians and other suppliers frequently incorrectly report the POS in which they furnish services. This improper billing is particularly problematic when physician and other suppliers furnish services in outpatient hospitals and in Ambulatory Surgical Centers (ASCs). In a sample of paid services (for services possessing both non-facility and facility practice expenses), the OIG found a significant percent of the sampled physician/practitioner claims were incorrectly reported by physician/practitioners as occurring in the office POS when those services were furnished in outpatient hospitals or ASCs. As such, these claims were paid by the Medicare contractor at the non-facility rate -- rather than the lower facility MPFS payment rate assigned to the POS codes for outpatient hospitals and ASCs.

The OIG has called on CMS to strengthen the education process and reemphasize to physicians (including non-physician practitioners and other suppliers) and their billing agents the importance of

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correctly coding the POS. Consequently, CR7631 adds special considerations provisions regarding use of POS codes 22 and 24, for outpatient hospitals and ASCs.

A previous CMS instruction, Transmittal 1873 (now rescinded) regarding the assignment of POS codes, instructed physicians to use the 2-digit POS code to describe where he/she was physically when rendering the service; in this instance, the POS code corresponded to the service location. (CMS 1500 Claim Form Items 24B and 32, respectively, and the corresponding loops on the ANSI 12X N 837-P electronic format information). The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable "locality" and Geographic Practice Cost Index (GPCI)-adjusted payment for each service paid under the MPFS.

CR7631 establishes that for all services – with two (2) exceptions -- paid under the MPFS, that the POS code to be used by the physician and other supplier will be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of MPFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician/practitioner will be the setting in which the beneficiary received the (Technical Component (TC) of the service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary's MRI from his/her office location – POS code 22 will be used on the physician's claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

There are two (2) exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a registered inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. The correct POS code assignment will be for that setting in which the beneficiary is receiving inpatient care or outpatient care from a hospital, including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22). In other words, reporting the inpatient hospital POS code 21 or the outpatient hospital POS code 22, is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient or an outpatient of a hospital respectively. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient (or hospital outpatient), the appropriate inpatient POS code (or appropriate outpatient POS code) may be reported consistent with the code list annotated in Pub. 100-04, Medicare Claims Processing Manual, Chapter 26, Section 10.5. However, it is more important that the physician/practitioner report the POS consistent with the patient's general inpatient or outpatient hospital status than the precise inpatient/ outpatient POS code (in order to trigger the facility payment rate under the PFS). "The Medicare Claims Processing Manual" (Chapter 26) already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the

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inpatient hospital and CR7631 clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well.

Facility and Non-Facility Payment Assignments

The list of settings where a physician's services are paid at the facility rate include:

- Inpatient Hospital (POS code 21);
- Outpatient Hospital (POS code 22);
- Emergency Room-Hospital (POS code 23);
- Medicare-participating Ambulatory Surgical Center (ASC) for a Healthcare Common Procedure Coding System (HCPCS) code included on the ASC approved list of procedures (POS code 24);
- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24);
- Military Treatment Facility (POS code 26);
- Skilled Nursing Facility (SNF) for a Part A resident (POS code 31);
- Hospice – for inpatient care (POS code 34);
- Ambulance – Land (POS code 41);
- Ambulance – Air or Water (POS code 42);
- Inpatient Psychiatric Facility (POS code 51);
- Psychiatric Facility -- Partial Hospitalization (POS code 52);
- Community Mental Health Center (POS code 53);
- Psychiatric Residential Treatment Center (POS code 56); and
- Comprehensive Inpatient Rehabilitation Facility (POS code 61).

Physicians' services are paid at non-facility rates for procedures furnished in the following settings:

- Pharmacy (POS code 01);
- School (POS code 03);

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- Homeless Shelter (POS code 04);
- Prison/Correctional Facility (POS code 09);
- Office (POS code 11);
- Home or Private Residence of Patient (POS code 12);
- Assisted Living Facility (POS code 13);
- Group Home (POS code 14);
- Mobile Unit (POS code 15);
- Temporary Lodging (POS code 16);
- Walk-in Retail Health Clinic (POS code 17);
- Urgent Care Facility (POS code 20);
- Birthing Center (POS code 25);
- Nursing Facility and Skilled Nursing Facilities (SNFs) to Part B residents –(POS code 32);
- Custodial Care Facility (POS code 33);
- Independent Clinic (POS code 49);
- Federally Qualified Health Center (POS code 50);
- Intermediate Health Care Facility/Mentally Retarded (POS code 54);
- Residential Substance Abuse Treatment Facility (POS code 55);
- Non-Residential Substance Abuse Treatment Facility (POS code 57);
- Mass Immunization Center (POS code 60);
- Comprehensive Outpatient Rehabilitation Facility (POS code 62);
- End-Stage Renal Disease Treatment Facility (POS code 65);
- State or Local Health Clinic (POS code 71);
- Rural Health Clinic (POS code 72);
- Independent Laboratory (POS code 81); and
- Other Place of Service (POS code 99).

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Special Guidance for Selected POS Codes

CR7631 adds clarifying or special consideration provisions for other settings as well. Those provisions are as follows:

Special Considerations for Mobile Unit Settings (Code 15)

When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician's office or a SNF. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity which could be described by an existing POS code, the providers are to use the Mobile Unit POS code 15. Medicare will apply the non-facility rate to payments for services designated as being furnished in POS code 15 and apply the appropriate facility or non-facility rate for the POS code designated when a code other than the mobile unit code is indicated.

A physician or practitioner's office, even if mobile, qualifies to serve as a telehealth originating site. Assuming such an office also fulfills the requirement that it be located in either a rural health Professional Shortage Area as defined under Section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a Metropolitan Statistical Area as defined in Section 1886(d)(2)(D) of the Social Security Act, the originating physician's office should use POS code 11 (Office) in order to ensure appropriate payment for services on the list of Medicare Telehealth Services.

Special Considerations for Walk-In Retail Health Clinic (Code 17) (Effective no later than May 1, 2010)

It should be noted that, while some entities in the industry may elect to use code 17 to track the setting of immunizations, Medicare continues to require its billing rules for immunizations claims, which are found in Chapter 18, Section 10 of the "Medicare Claims Processing Manual" found at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf> on the CMS website. Providers and suppliers of immunizations must continue to follow these Medicare billing rules. However, Medicare contractors will accept and adjudicate claims containing POS code 17, even if its presence on a claim is contrary to these billing instructions.

Special Considerations for Services Furnished to Registered Inpatients

When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, will, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF

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receiving inpatient skilled nursing care, POS 51, for a patient registered in a Psychiatric Inpatient Facility, and POS 61 for patients registered in a Comprehensive Inpatient Rehabilitation Facility.

Special Considerations for Outpatient Hospital Departments

When a physician/practitioner furnishes services to an outpatient of a hospital, payment is made under the MPFS at the facility rate. Physicians/practitioners who furnish services to a hospital outpatient, including in a hospital outpatient department (including in a provider-based department of that hospital) or under arrangement to a hospital will, at a minimum, report the outpatient hospital POS code 22 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the outpatient hospital POS code 22 is a minimum requirement for purposes of triggering the facility payment amount under the PFS when services are provided to a registered outpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered hospital outpatient, the appropriate outpatient facility POS code may be reported consistent with the code list annotated in this section (instead of POS 22). For example, physicians/practitioners may use POS code 23 for services furnished to a patient registered in the emergency room, POS 24 for patients registered in an ambulatory surgical center, and POS 56 for patients registered in a psychiatric residential treatment center.

NOTE: Physicians/practitioners who perform services in a hospital outpatient department will use, at a minimum, POS code 22 (Outpatient Hospital). Code 22 (or other appropriate outpatient department POS code as described above) will be used unless the physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65. Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.6. Use of POS code 11 (office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

Special Consideration for Ambulatory Surgical Centers (Code 24)

When a physician/practitioner furnishes services to a patient in a Medicare-participating ASC, the POS code 24 (ASC) will be used.

NOTE: Physicians/practitioners who perform services in a Medicare-participating ASC will use POS code 24 (ASC). Physicians are not to use POS code 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC which meets all other requirements for operating as a physician office at the same physical location as the ASC – including meeting the “distinct entity” criteria defined in the ASC State Operations Manual that precludes the ASC and an adjacent physician office from being open at the same time -- and the physician service was actually performed in the office suite portion of the facility. That information is in Appendix L of that manual which is at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_1_ambulatory.pdf on the CMS website.

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Special Considerations for Hospice (Code 34)

When a physician/practitioner furnishes services to a patient under the hospice benefit, use the following guidelines to identify the appropriate POS.

When a beneficiary is in an "inpatient" respite or general "inpatient" care stay, the POS code 34 (hospice) will be used. When a beneficiary who has elected coverage under the Hospice benefit is receiving inpatient hospice care in a hospital, SNF, or hospice inpatient facility, POS code 34 (Hospice) will be used to designate the POS on the claim.

For services provided to a hospice beneficiary in an outpatient setting, such as the physician/nonphysician practitioner's office (POS 11); the beneficiary's home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., outpatient hospital (POS 22)), the patient's physician or nonphysician practitioner or hospice independent attending physician or nurse practitioner, will assign the POS code that represents that setting, as appropriate.

There may be use of nursing homes as the hospice patient's "home," where the patient resides in the facility but is receiving a home level of care. In addition, hospices are also operating "houses" or hospice residential entities where hospice patients receive a home level of care. In these cases, physicians and nonphysician practitioners, including the patient's independent attending physician or nurse practitioner, will use the appropriate POS code representing the particular setting, e.g., POS code 32 for nursing home, POS code 13 for an assisted living facility, or POS code 14 for group home.

Clarifications Regarding Global Services

When a physician performs a diagnostic test under arrangement to a hospital and the test and the interpretation are not separately billable, the interpretation cannot be billed by the physician. In this scenario, the hospital is the only entity that can bill for the diagnostic test which encompasses the interpretation. There is no POS code for the interpretation since a physician claim is not generated.

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 or supplier entity and the PC and TC components are furnished within the same MPFS payment locality. Merely applying the same POS code to the PC as that of the TC does not permit global billing for any diagnostic procedure.

Clarification Regarding Determination of Payment Locality

Under the MPFS, payment amounts are based on the relative resources required to provide services and vary among payment localities as resource costs vary geographically as measured by the geographic practice cost indices (GPCIs). The payment locality is determined based on the location where a specific service code was furnished. For purposes of determining the appropriate payment locality, CMS requires that the address, including the ZIP code for each service code be included on the claim form in order to determine the appropriate payment locality. The location in which the service code was furnished is entered in Item 32 on the paper claim Form CMS 1500 (or its electronic equivalent).

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Global Service Code

If the global diagnostic service code is billed, the biller (either the entity that took the test, physician who interpreted the test, or separate billing agent) must report the address and ZIP code of where the test was furnished on the bill for the global diagnostic service code. In other words, when the global diagnostic service code is billed, for example, chest x-ray as described by HCPCS code 71010 (no modifier TC and no modifier -26), the locality is determined by the ZIP code applicable to the testing facility, i.e. where the TC of the chest x-ray was furnished. The testing facility (or its billing agent) enters the address and ZIP code of the setting/location where the test took place. This practice location is entered in Item 32 on the paper claim Form CMS 1500 (or its electronic equivalent). As explained above, in order to bill for a global diagnostic service code, the same physician or supplier entity must furnish both the TC and the PC of the diagnostic service and the TC and PC must be furnished within the same MPFS payment locality.

A listing of the current PFS locality structure, including state, locality area (and when applicable, counties assigned to each locality area) may be accessed from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html> on the CMS website. (Select "Medicare PFS Locality Configuration" from the menu on left.)

Separate Billing of Professional Interpretation

If the same physician or other supplier entity does not furnish both the TC and PC of the diagnostic service, or if the same physician or other supplier entity furnishes both the TC and PC but the professional interpretation was furnished in a different payment locality from where the TC was furnished, the professional interpretation of a diagnostic test must be separately billed with modifier -26 by the interpreting physician.

When the physician's interpretation of a diagnostic test is billed separately from the technical component, as identified by modifier -26, the interpreting physician (or his or her billing agent) must report the address and ZIP code of the interpreting physician's location on the claim form. If the professional interpretation was furnished at an unusual and infrequent location for example, a hotel, the locality of the professional interpretation is determined based on the Medicare enrolled location where the interpreting physician most commonly practices. The address and ZIP code of this practice location is entered in Item 32 on the paper claim Form CMS 1500 (or its electronic equivalent).

Additional Information

The official instruction, CR7631 issued to your carrier and/or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2561CP.pdf> on the CMS website.

If you have any questions about the correct POS code to use, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

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News Flash - Vaccination is the Best Protection Against the Flu - Each office visit is an opportunity to check your patients' seasonal influenza (flu) and pneumonia immunization status and to start protecting your patients as soon as your 2012-2013 seasonal flu vaccine arrives. Ninety percent of flu-related deaths and more than half of flu-related hospitalizations occur in people age 65 and older. Seniors also have an increased risk of getting pneumonia, a complication of the flu. Remind your patients that seasonal flu vaccinations and a pneumococcal vaccination are recommended for optimal protection.

Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare beneficiaries. Medicare generally provides coverage of pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries. Medicare may provide coverage of additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. Medicare provides coverage for these vaccines and their administration with no co-pay or deductible. Also, don't forget to immunize yourself and your staff. *Know what to do about the flu.*

Remember – Influenza vaccine plus its administration is a covered Part B benefit. Influenza vaccine is NOT a Part D covered drug. CMS will provide information and a link to the 2012-2013 Influenza Vaccine prices when they are available. For more information on coverage and billing of the flu vaccine and its administration, please visit the [CMS Medicare Learning Network® Preventive Services Educational Products](#) and [CMS Immunizations](#) web pages. While some providers may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. [HealthMap Vaccine Finder](#) is a free, online service where users can search for locations offering flu vaccines. .

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