

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



News Flash – Are you billing correctly for ordered/referred services? Will you be impacted when CMS turns on the edits for these services? See the revised MLN Matters® articles [#SE1221](#), [#SE1011](#), and MLN fact sheets [“Medicare Enrollment Guidelines for Ordering/Referring Providers”](#) and [“The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement”](#) to learn what you need to do.

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Reminder of Importance of Correct Place-of-Service Coding on Medicare Part B Claims

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians and their billing agents who submit claims to Medicare Carriers or Medicare Administrative Contractors (A/B MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) is issuing this article to remind providers that accurate place of service coding on claims is essential to avoid improper payments. Make sure that your billing staffs are aware of this article and the need to correctly code the place-of-service on your Medicare claims.

Background

The Medicare Part B Program pays for physician services provided to beneficiaries. Physicians may perform these services in a **facility setting**, such as a hospital outpatient department or freestanding Ambulatory Surgical Center (ASC), or in a **non-facility setting** such as a physician's office, urgent

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care center, or independent clinic. To account for the increased overhead expenses physicians incur by performing these services in non-facility locations, Medicare reimburses physicians based on a fee schedule that may pay a higher rate for individual services provided in these locations. When physicians perform these services in facility settings, such as hospital outpatient departments or ASCs, Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate.

Physicians are required to identify the place-of-service on the health insurance claim forms that they submit to Medicare contractors. The correct place-of-service code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the payment if the service was performed in a facility setting.

The Office of Inspector General (OIG) conducted an audit in 2009 that followed up on a similar audit from a 2007 report. The 2009 audit covered 494,129 non-facility-coded physician services valued at \$42,245,142. These services were provided in calendar year 2009 and matched hospital outpatient or ASC claims for the same type of service provided to the same beneficiary on the same day.

The OIG conducted the 2009 audit to determine whether physicians correctly coded non-facility place-of-service on selected part B claims submitted to and paid by Medicare contractors. The audit report, titled "Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009" is available at <http://oig.hhs.gov/oas/reports/region10/11000516.pdf> on the OIG website.

Results of Recent OIG Audit

Physicians correctly coded the claims for 17 of the 100 services that the OIG sampled. However, physicians incorrectly coded the claims for 83 sampled services by using non-facility place-of-service codes for services that were actually performed in hospital outpatient departments or ASCs.

Based on the sample results, OIG estimated that nationally, Medicare contractors overpaid physicians \$9.5 million for incorrectly coded services provided during calendar year 2009. These overpayments may be due to internal control weaknesses at the physician billing level. They may also be attributed to insufficient post-payment reviews at the Medicare contractor level to identify potential place-of-service coding errors.

As a result, Strategic Health Solutions, a CMS contractor, performed a specialty medical review study on Place-of-Service coding for physician services. This study concluded that the most common finding was documentation submitted indicated that the service was incorrectly coded as a non-facility place of service. In addition, a number of providers acknowledged that the claim was coded incorrectly upon receipt of the documentation, or had already initiated the adjustment process.

Additional Information

For an overview of place of service coding and a list of the appropriate codes, visit https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html on the CMS website.

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If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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