

**Audio Title: Revised and Clarified Place of Service (POS) Coding Instructions**

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Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or “CMS.” These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for health care professionals.

If you bill Medicare Administrative Contractors, or MACs, for services paid under the Medicare Physician Fee Schedule, or MPFS then you will benefit from this podcast. This podcast is intended for physicians, providers, and suppliers.

This podcast, based on MLN Matters® Article MM7631, is about revised and clarified national policy for place of service, or POS, code assignment.

Clarification on the place of service for pathology and laboratory services can be found in MLN Matters® Article MM8399. Specific instructions for downloading this article can be found at the end of this podcast.

The instructions in MM7631 regard assignment of POS for all services paid under the Medicare Physician Fee Schedule (MPFS) and certain services provided by independent laboratories. Also, instructions are given for the interpretation of Professional Component (PC) and Technical Component (TC) of diagnostic tests. It is important that you make your billing staff aware of these changes.

The background for this policy can be found on pages two through four of MM7631.

There is a list of settings where a physician’s services are paid at the facility rate. These settings can be found on page four of MM7631.

There is also a list where physician’s services are paid at non-facility rates for procedures given in specific settings. These settings can be found on pages five and six of MM7631.

First, we’ll discuss special guidance for selected POS codes. For instance, there are special considerations for mobile unit settings (code 15) that says when a mobile unit gives services, they are often provided to serve an entity for which another POS code exists. For example, a physician’s office or a Skilled Nursing Facility (SNF) may have a mobile unit sent to them. If the mobile unit is serving an entity for which another POS code already exists, you should use the POS code for that entity. However, if the mobile unit is not serving an entity that could be described by an existing POS code, you are to use the Mobile Unit POS code 15. Medicare will apply the non-facility rate to payments for services designated as being given in POS code 15 and apply the appropriate facility or non-facility rate for the POS code given when a code other than the mobile unit code is indicated.



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A physician's or practitioner's office, even if mobile, qualifies to serve as a telehealth originating site as long as it can fulfill the requirements that it be located in either a rural health Professional Shortage Area or in a county that is not included in a Metropolitan Statistical Area. See page six of MLN Matters article MM7631 for definitions of these areas. 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.

Next, we'll discuss special considerations for walk-in retail health clinics (Code 17). Some entities in the industry may choose to use code 17 to track the setting of immunizations; however, Medicare continues to require its billing rules for immunization claims. You can find these rules in Chapter 18, section 10 of the "Medicare Claims Processing Manual." Providers and suppliers of immunizations must continue to follow these Medicare billing rules. Medicare contractors will accept and adjudicate claims containing POS code 17, even if its presence on a claim conflicts with these billing instructions.

Now, we'll discuss special considerations for services given to registered inpatients. When you give a service to a registered inpatient, payment is made under the MPFS at the facility rate. If you give services to a registered inpatient, you will, at a minimum, report the inpatient hospital POS code 21 regardless of the setting where the patient actually receives the face-to-face meeting. Reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under MPFS when services are provided to a registered inpatient. If the physician or practitioner is aware of the exact setting where the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list noted in this section. For example, you may use POS 31 for a patient in a SNF 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.

There are also special considerations for outpatient hospital departments including when a physician or practitioner gives services to an outpatient of a hospital. Then payment is made under the MPFS at the facility rate. If you give services to a hospital outpatient, including in a hospital outpatient department or under arrangement to a hospital, at a minimum, you will report the outpatient hospital POS code 22 regardless of the setting where the patient actually receives the face-to-face meeting. Reporting the POS code 22 is a minimum requirement for purposes of triggering the facility payment amount under the MPFS when services are provided to a registered outpatient. If you are aware of the exact setting where the beneficiary is a registered outpatient, the appropriate outpatient facility POS code may be reported consistent with the code list in this section. For example, you may use POS code 23 for services given 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 psychiatric residential treatment centers. Please note, physicians will use POS code 11 when services are provided in a separately maintained physician office space in the hospital or on a hospital campus and that physician's office space is not considered a provider-based department of the hospital. For more information, see 42 CFR 411.353 through 411.357, as well as 413.6 and 413.65.

Next, we'll discuss special considerations for Ambulatory Surgical Centers, or ASCs. When furnishing services to a patient in a Medicare-participating ASC, the POS code 24 will be used. Please note, you are not to use POS code 11 (office) for ASC based services unless you have an office at the same physical location of the ASC. The ASC must meet all other requirements for operating as a physician office at the same location as the ASC. This includes meeting the "distinct entity" criteria defined in the "ASC State Operations Manual" that stops the ASC and a physician's office next to you from being open at the same



**Contact: [MLN@cms.hhs.gov](mailto:MLN@cms.hhs.gov)**

time and the physician service was actually performed in the office suite portion of the facility. This information can be found in Appendix L of the “State Operations Manual.”

Special considerations are in place for hospice as well. When a beneficiary is in an inpatient respite or general inpatient care stay, the POS code 34 (hospice) will be used. If a beneficiary has chosen coverage under the Hospice benefit and is receiving inpatient hospice care in a hospital, SNF, or hospice inpatient facility, POS code 34 (hospice) will be used to describe the POS on the claim. If you provide services to a hospice beneficiary in an outpatient setting, such as the physician or nonphysician practitioner’s office (POS 11), the beneficiary’s home (POS 12), i.e., not operated by the hospice or other outpatient setting, for example 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 stands for that setting, as appropriate.

There may be use of nursing homes as the hospice patient’s home, where the patient lives in the facility but is receiving a home level of care. Also, hospices are also operating houses or hospice residential entities where hospice patients receive a home level of care. In these cases, you will use the appropriate POS code representing the particular setting. For example, POS code 32 for nursing home, POS code 13 for an assisted living facility, or POS code 14 for group home.

Now, we’ll discuss clarifications regarding global services. When a physician performs a diagnostic test under arrangement to a hospital and the test and interpretation are not separately billable, you cannot bill for the interpretation. In this scenario, the hospital is the only entity that can bill for the diagnostic test, which includes 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 given by the same physician or supplier entity and both components are given 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.

Next, we’ll discuss 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 given. For purposes of determining the appropriate payment locality, CMS requires that the address, including 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 given is entered into Item 32 on the paper claim Form CMS-1500, or its electronic equivalent.

Now, we’ll discuss global service codes. 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 given 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



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testing facility (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 or 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. Remember, in order to bill for a global diagnostic code, the same physician or supplier entity must give both the TC and PC of the diagnostic service and the TC and PC must be given within the same MPFS payment locality.

Finally, we'll discuss separate billing of professional interpretation. If the same physician or other supplier entity does not give both the TC and PC of the diagnostic service, or if the same physician or other supplier entity gives both the TC and PC, but the professional interpretation was given in a different payment locality from where the TC was given, the professional interpretation of a diagnostic test must be separately billed with modifier -26 by the interpreting physician.

When your interpretation of a diagnostic test is billed separately from the technical component, as identified by modifier -26, the interpreting physician (or billing agent) must report the address and zip code of the interpreting physician's location on the claim form. If the professional interpretation was given 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.

There are some additional helpful resources to guide you in your POS coding. These resources can be located on page ten of MM7631.

To download the MLN Matters® Articles MM7631, and MM8399, also referenced in this podcast, go to the CMS website at [www.cms.gov](http://www.cms.gov) and click on "Outreach and Education" at the top of the page. From that page, scroll down to the Medicare Learning Network section and click on the MLN Matters® Articles link. Follow the links to "2013 MLN Matters® Articles" and search for the MM article numbers.

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