Claims and Payment Policy: Appropriate Place of Service (POS) Billing (IH146)

Policy Number: CPP- 144

BACKGROUND

According to CMS, the rate, facility or nonfacility, that a physician service is paid under the Medicare Physician Fee Schedule (MPFS) is determined by the Place of Service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NPP) or other supplier.

In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or nonfacility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred.

POSITION STATEMENT

The Place of Service policy will address the reimbursement of Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that are reported in a place of service (POS) considered inappropriate based on the code's description or available coding guidelines when reported by a physician or other health care professional.

Wellcare will reimburse CPT and HCPCS codes when reported with an appropriate Place Of Service (POS). Wellcare aligns with CMS POS Code set, which are two-digit codes submitted on the CMS 1500 claim form or its electronic equivalent to indicate the setting in which a service was provided. The website containing the POS Code Set can be accessed via this link:
https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

What Does this Mean for Providers?

Facility Rates

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

Description	POS Code
Telehealth	02
Outpatient Hospital-Off campus	19
Inpatient Hospital	21
Outpatient Hospital-On campus	22
Emergency Room-Hospital	23
Medicare-participating ambulatory surgical center (ASC) for a HCPCS code included on the ASC approved list of procedures	24

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Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008.	24
Military Treatment Facility	26
Skilled Nursing Facility (SNF) for a Part A resident	31
Hospice – for inpatient care	34
Ambulance – Land	41
Ambulance – Air or Water	42
Inpatient Psychiatric Facility	51
Psychiatric Facility	52
Community Mental Health Center	53
Psychiatric Residential Treatment Center	56
Comprehensive Inpatient Rehabilitation Facility	61

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. A physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter.

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).

Providers may receive an IH146: “Denied: Place of Service Not Consistent with Claim History” claim denial if any service (other than inpatient care) is billed by any professional provider on the same date of service as inpatient care but with a different place of service, when the member also received inpatient care the previous day and was not discharged on the same day, or on the subsequent day.

Special Consideration for Services Furnished to Outpatient Hospital

Providers may also receive an IH146 denial for services billed in place of service 19 (Outpatient Hospital - Off campus), 22 (Outpatient Hospital - On campus) or 23 (Emergency Room - Hospital) by any professional provider on the same date of service as inpatient care, when the member also received inpatient care the previous day and was not discharged.

Non-Facility Rates

Physicians services are paid at nonfacility rates for procedures furnished in the following settings:

Description	POS Code
Pharmacy	01
School	03
Homeless Shelter	04

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

Special Consideration for Services Furnished in the Office Setting

Providers may receive an IH146: “Denied: Place of Service Not Consistent with Claim History” claim denial for any physician service code when billed in Place of Service 11 (Office) by a professional provider and the same code was billed by any outpatient hospital for the same date of service.

Special Consideration for Georgia Medicaid in POS 03 (School)

In accordance with Georgia Medicaid EPSDT policies for Health Check Services Health Check Program, providers may receive an IH146: “Denied: Place of Service Not Consistent with Claim History” claim denial if any procedure codes **other than** 90655, 90656, 90657, 90658, & 90660 arebilled in POS 03. Only influenza vaccine services will be reimbursed at school-based clinics.

Post Payment Review

Providers may also have claims reviewed for recovery of overpayments if codes that are reported in a place of service (POS) considered inappropriate based on the code’s description or available coding guidelines when reported by a physician or other health care professional.

CODING & BILLING

Many CPT and HCPCS codes include a place of service (POS) in their description or in their coding guidelines which indicate the place(s) of service where the code may be performed. Wellcare utilizes these assigments to determine POS.

Non-Facility Indicator "NA"

According to the CMS National Physician Fee Schedule Relative Value File, the Non-Facility Indicator identified as "NA" indicates that "this procedure is rarely or never performed in the non-facility setting." Wellcare will not reimburse CPT and HCPCS codes assigned the Non-Facility Indicator "NA" when reported without an appropriate POS.

A link to the CMS National Physician Fee Schedule Relative Value File which displays the CPT and HCPCS codes assigned the Non-Facility Indicator "NA". Wellcare will not reimburse these codes in a non-facility place of service: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

DEFINITIONS

Place of Service	A two-digit code used on health care professional claims to indicate the setting in which a service was provided.
Procedure and Place of Service List	A list of codes that include a place of service in their description or coding guidelines or include the place(s) of service where the code may be performed (see attachment)

REFERENCES

1. Centers for Medicare and Medicaid Services, National Physician Fee Schedule (NPFS), Retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files. Accessed December 4, 2019.
2. CMS Place of Service Code Sets. Retrieved from: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set. Accessed December 4, 2019.
3. CMS Manual Pub 100-04 Medicare Claims Processing Transmittal 3873 Retrieved from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3873CP.pdf. Accessed December 4, 2019.
4. Policies and Procedures for Early Periodic Screenings, Diagnostic and Treatment (EPSDT) Services-Health Check Program (COS 600). Georgia Department of Community Health Division of Medicaid. Revised October 1, 2019. Retreived from: : https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Health%20Check%20Program%20-%20EPSDT%2020190930185201.pdf Accessed January 14, 2020.
5. Medicare Claims Processing Manual, Chapter 26-Completing and Processing Form CMS-1500 Data Set. Retreived from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf Accessed January 14, 2020.
6. Medicare Claims Processing Manual, Chapter 12- Physicians/Nonphysicians Practitioners. Retreived from: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf Accessed January 14, 2020.

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

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RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
3/23/2020	• Approved by RGC