Place of Service Coding
Teleconference

June 4, 2014

Part B Provider Outreach and Education
Today’s event is a teleconference

Slides will not be advanced during the presentation

Attendees are instructed to refer to their handout material

All lines will be placed on mute until the question and answer period

There will be a live Q&A session after the presentation

To participate in the teleconference please dial

- Telephone number: 1-800-791-2345
- Access code: 88096
This resource is not a legal document. This presentation was prepared as a tool to assist our providers. This presentation was current at the time it was created. Although, every reasonable effort has been made to assure accurate information, responsibility for correct claims submission lies with the provider of services. Reproduction of this material for profit is prohibited.

CPT Disclaimer American Medical Association (AMA) Notice and Disclaimer

Current Procedural Terminology (CPT) only copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association (AMA). Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.
Today’s Agenda

Office of Inspector General (OIG) Report
Change Request 7631
Common POS Errors
Medicare Updates
Q&A Session
Closing Remarks
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Final rule published in the Federal Register, August 17, 2000, adopted standards and implementation standards

Guide requires use of Place of Service codes from the National POS code set
  - Maintained by the Centers for Medicare and Medicaid Services (CMS)

Medicare must recognize as valid POS codes from the national code set

Medicare instructions found at CMS IOM Publication 100-04 Ch. 26 Section 10.5
Based on consistent findings from OIG reports from CY 2002 through CY 2007

- Improper billing when services furnished in outpatient hospitals and ambulatory surgical centers
- Sample reviewed found sampled claims were incorrectly reported as occurring in the office POS when services were furnished in outpatient hospitals or ASCs
- As a result, claims were paid by the contractor at the non-facility rate -- rather than the lower facility MPFS payment rate assigned to the POS codes for outpatient hospitals and ASCs
Non-facility rate

- Represents the provider’s direct/indirect costs related to providing that service in an office/clinic setting, patient home or other non-facility setting. Expenses may include rent for office space, employees, supplies, utilities, etc.

Facility rate (Results in lesser payment)

- Represent cost associated with service in a facility setting. Expenses of rent, supplies, labor and equipment are part of the cost of the facility where the service is being rendered.

CMS manual instructions are found at Pub 100-04 Medicare Claims Processing Chapter 12 Section 20.4.2 Site of Service Payment Differential
Example of fee differential based on CPT code 99214 – 99215

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>MODIFIER</th>
<th>SHORT DESCRIPTION</th>
<th>PROC STAT</th>
<th>CARRIER LOCALITY</th>
<th>NON-FACILITY PRICE</th>
<th>FACILITY PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>99214</td>
<td></td>
<td>Office/outpatient visit est</td>
<td>A</td>
<td>1020201</td>
<td>$108.19</td>
<td>$79.25</td>
</tr>
<tr>
<td>99214</td>
<td></td>
<td>Office/outpatient visit est</td>
<td>A</td>
<td>1020299</td>
<td>$102.42</td>
<td>$76.66</td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td>Office/outpatient visit est</td>
<td>A</td>
<td>1020201</td>
<td>$144.83</td>
<td>$111.54</td>
</tr>
<tr>
<td>99215</td>
<td></td>
<td>Office/outpatient visit est</td>
<td>A</td>
<td>1020299</td>
<td>$137.50</td>
<td>$107.87</td>
</tr>
</tbody>
</table>

Snapshot of 2014 Physician Fee Schedule as shown from CMS Look-up Tool

Georgia Locality Pricing
### Facility
- Inpatient Hospital (21)
- Outpatient Hospital (22)
- Emergency Room (23)
- Ambulatory Surgical Center (24)
- Skilled Nursing Facility (31) for a Part A resident
- Hospice for inpatient care (34)
- Inpatient Psych Facility (51)
- Psych Facility-Partial Hosp (52)
- Community Mental Hlth Ctr (53)
- Psych Residential Treatment Ctr (56)
- Comp Inpatient Rehab Facility (61)

### Non-Facility
- Office (11)
- Home or Private Residence (12)
- Assisted Living Facility (13)
- Group Home (14)
- Mobile Unit (15)
- Walk-in Retail Health Clinic (17)
- Urgent Care Facility (20)
- Nursing Facility (32)
- Mass Immunization Center (60)
- State or Local Health Clinic (71)
- Independent Laboratory (81)
- Other Place of Service (99)

*Refer to the job aid attachment for a complete POS listing*
Revised and Clarified Place Of Service (POS) Coding Instructions

- Change Request #7631
- Effective: April 1, 2013
- Implementation: April 1, 2013

Key Points:
- Based on findings from the Office of Inspector General (OIG)
- Adds provisions regarding use of POS codes 22 and 24
- The POS code to be used will be assigned as the same setting in which the beneficiary received the face-to-face service
- Two exceptions to this face-to-face provision/rule
- Amended POS instructions for Professional Component (PC) and Technical Component of diagnostic testing
Revised instructions establish that POS shall be same setting in which beneficiary received face-to-face encounter.

Two exceptions to the face-to-face provision/rule:
- Beneficiary receiving care as hospital inpatient; or
- Receiving care as outpatient of a hospital.
Special Considerations
(POS 15 – Mobile Unit)

❖ Mobile unit serves the entity (e.g. Unit may be sent to physician’s office)
  o If used strictly for mobile unit then POS code 15 is appropriate (i.e., IDTF services)
  o Payment made at the non-facility rate

❖ Clarification for telehealth originating site
  o Office setting that fulfills requirements of under-served areas must be met
    • Health Professional Shortage Area
    • County not included in Metropolitan Statistical Area
  o Appropriate payment should reflect telehealth services
Special Considerations
(POS 17—Walk-In Unit)

- Effective no later than May 1, 2010
- Mainly used to track immunizations
- Does not take the place of Medicare billing rules for billing immunizations (e.g., Roster billing use POS 60)
- Payment made at the non-facility rate
Services furnished to a patient who is an *inpatient* of a hospital, the inpatient hospital POS code 21 shall be used irrespective of the setting where the patient actually receives the face-to-face encounter.

Services furnished 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 shall use POS code 22.

POS code 11 used ONLY when

- Services are performed in a separately maintained physician office space in the hospital or on the hospital campus
- Physician office space is not considered a provider-based department of the hospital
When a physician/practitioner furnishes services to a patient in a Medicare-participating ASC, the POS code 24 shall be used.

Physicians/practitioners are not to use POS code 11 (office) for ASC based services:

- Meets all other requirements for operating as a physician office at the same physical location as the ASC
- “Distinct entity” criteria defined in the ASC State Operations Manual

Please note: Payment for POS code 21, 22 and 24 made at the facility rate.
When a beneficiary is in an “inpatient” respite or general “inpatient” care stay, the POS code 34 (hospice) shall be used
- Payment made at the facility rate

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
- Assign the POS code that represents that setting, as appropriate
Many of the diagnostic services, including radiology services, provided by physicians/practitioners contain both a professional component (PC) and a technical component (TC). Often, the PC and TC of diagnostic services are furnished in different settings. As a general policy, the POS code assigned by the physician/practitioner for the PC of a diagnostic service shall be the setting in which the beneficiary received the TC service.

Reference: CMS IOM Pub 100 – 04 Medicare Claims Processing Manual Chapter 13 Section 150
Interpretation provided telephonically by Wireless Remote

- Applicable to teleradiology services (radiology services that do not require a face-to-face with the patient)

- Examples include x-ray, electrocardiogram, electroencephalogram

- Additional information found in CMS IOM Pub. 100-02 Medicare Benefit Policy Manual, Ch. 15, Section 30
Interpretation provided telephonically by Wireless Remote

- Many diagnostic services, including radiology services, contain both a professional component (PC) and technical component (TC) portion.

- POS code assigned for the PC of a diagnostic service shall be the setting where TC service was received.
Interpretation provided telephonically by Wireless Remote

Example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The outpatient 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 (Outpatient Hospital) shall be used on the physician’s claim to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital. The physician enters the address and ZIP code of his/her office location so that the appropriate payment locality can be determined.
Interpretation provided outside of the United States

- Generally, Medicare will not pay for healthcare outside U.S.
- Term “outside the U.S.” means anywhere outside 50 states, DC, Puerto Rico, E.S. Virgin Islands, Guam, American Samoa, and Northern Mariana Islands
- **Exceptions** for exclusion found at Pub. 100-02, Chapter 16, Section 60

Interpretation provided under arrangement – To A Hospital

- **Separate TC and PC**
  - Physician who reads the test can bill and be paid for the PC
  - POS code for the interpretation (or PC) is the setting where the beneficiary received the TC service
  - *Physician’s office performed the interpretation and patient received the TC service in provider-based outpatient hospital setting, assign POS code 22*

- **Global Service**
  - Test and interpretation not billed separately
  - Physician cannot bill interpretation
  - Hospital is the only entity that can bill
  - There is no POS code for the interpretation
Global Billing

- Codes that are split into a PC and TC component
  - Service furnished by the same physician or supplier entity
  - Furnished within the same MPFS payment locality
- Used in the POS code set identified as a non-facility setting
- No purchased test provided for diagnostic test
Remark code M77

Missing/incomplete/invalid place of service

– Verify the POS used on the claim is a two-digit numeric code
– Make sure the POS code and procedure are compatible
– Verify the place of service code is current and contains both digits in Item 24B of the CMS 1500 claim form or Loop 2300 (claim level) of electronic
Provider submits claim for office visit (CPT 99213) with inpatient hospital place of service (21). Cahaba GBA will deny service since POS code is not compatible with the CPT code. Review your current CPT manual to determine if the correct procedure code was billed.
Provider submits claim for office visit (CPT 99213) with nursing home place of service (32). Cahaba GBA will deny service since POS code is not compatible with the CPT code. Review your current CPT manual to determine if the correct procedure code was billed.
Provider submits claim for an echocardiography (CPT 93307) billed in an outpatient hospital (22) place of service. Medicare Part B does not reimburse global services for diagnostic test in a facility setting. CMS manual instructions are available located in Change Request 7631.
Always verify your place of service

Review the CMS National POS code set

Two-digit numeric code is required

Claim form data element

- CMS 1500 - Item 24B
- Electronic claim - Loop 2400 (Version 5010)

Become familiar with the exceptions listed in CR7631
Resources

CR7631 – Revised and Clarified POS

SE1313 - POS Coding Physician Services in an Outpatient Setting

FAQs Related to CR7631
Medicare Updates

CMS and Cahaba GBA Reminders
Cahaba GBA will raise the cost to $10
  - Current fee is $5.00

Fee change will be effective July 1, 2014

Cost of postage and supplies have increased

Applies to the duplicate RA and Health Professional Shortage Area (HPSA) report
Provider Enrollment Webpage Update

Enrollment

The Medicare Provider Enrollment department is dedicated to providing you with quality service. Processing an eligible Medicare provider/supplier application requires extensive research to insure all information provided is accurate and all appropriate attachments are supplied. Absent extenuating circumstances, the processing time for Medicare application forms, CMS 855I, and CMS 855B must be within 60 calendar days of receipt into our department. The CMS 855R and any changes must be processed within 45 calendar days of receipt.

- **CMS Enrollment Website** – Provider/Suppliers can view current CMS Enrollment Information directly from the following location. The web site will provide the most current CMS Provider Enrollment information, forms and commonly asked questions.

**Top Reasons for Development**

- Contact person signs section 6A instead of AO/DO
- Section 15, section 4A and/or 4B missing either signature or date
- Section 3 Adverse Legal not completed
- Section 1 missing individual NPI and PTAN
- Section 2 missing SSN
- Correct AO/DO signatures
- Clarify purpose because Section 1 incomplete
- 855I section 4 , missing group name, NPI and PTAN
- 855B, section 4, practice location information
- CMS 588 EFT form along with preprinted voided check or letter from bank
- Incomplete apps in PECOS. PECOS PI should indicate 100% complete
- Type 2 NPI and CP575 for sole owners who are incorporated (PA, LLC, INC, PLLC)
# Calendar of Events

## Provider Outreach and Education Part B

<table>
<thead>
<tr>
<th>Date</th>
<th>Seminar Type</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>06-04-2014</td>
<td><strong>Place of Service Coding</strong> <em>(Registration closed)</em></td>
<td>Teleconference</td>
</tr>
<tr>
<td>06-05-2014</td>
<td><strong>CERT: Documentation for Computed Tomography (CT) scans</strong> <em>(Registration closed)</em></td>
<td>Webinar</td>
</tr>
<tr>
<td>06-18-2014</td>
<td><strong>Ask Cahaba B:</strong> <em>(CMS Quarterly Updates and Resources)</em></td>
<td>Teleconference</td>
</tr>
<tr>
<td>06-18-2014</td>
<td><strong>Small Provider Workshop</strong></td>
<td>Oak Ridge, TN</td>
</tr>
<tr>
<td>08-06-2014 to 08-07-2014</td>
<td><strong>Cahaba GBA 2014 Medicare Expo</strong> <em>(Coming Soon!)</em></td>
<td>Chattanooga, TN</td>
</tr>
</tbody>
</table>

https://apps.cahabagba.com/apps/course_registration/al/calendar.jsp
The Comprehensive Error Rate Testing (CERT) program was initiated by CMS to emphasize accountability, pay claims appropriately, and to provide a renewed focus on provider compliance error rate. The paid claim error rate is a measure of the extent to which providers are paying claims correctly. The provider compliance error rate is a measure of the extent to which submitting claims correctly.

The program has independent medical reviewers periodically reviewing representative Medicare claims that are identified as soon as they are accepted into the claims. The independent reviewers medically review claims that are paid, by contrast, claims that are not paid, and ensure that the decision was appropriate.

There are two contractors who administer the CERT Program on behalf of CMS. The CERT program selects random samples of claims from each Medicare claims processing contractor. For each claim selected, the CERT Documentation Contractor (CDC) requests medical records from the physicians and non-physician providers who billed for the services, tracks record receipts, and prepares the documentation for review. Using the medical record documentation received, the contractors verify that the services were billed correctly, and that the Carrier and Fiscal Intermediary (FI) decisions regarding the payment and processing of the claim(s) were accurate and based on sound policy. Claims that are billed, paid, or processed incorrectly are categorized as errors.

Use the following resources to learn more about the program:

- CERT Brochure
- CERT Computer Based Training (CBT)
- Evaluation & Management Documentation Guidelines
- Frequently Asked Questions About CERT
- Signature Guidelines for Medical Review Purposes

---

Monthly Recent Comprehensive Error Rate Testing (CERT) Findings

2014
- Claim Specific CERT Errors April 2014
- Claim Specific CERT Errors March 2014
- Claim Specific CERT Errors February 2014
- Claim Specific CERT Errors January 2014

2013
- Claim Specific CERT Errors December 2013
- Claim Specific CERT Errors November 2013
- Claim Specific CERT Errors October 2013
- Claim Specific CERT Errors September 2013
- Claim Specific CERT Errors August 2013
- Claim Specific CERT Errors July 2013
ICD-10: A New Compliance Date

Visit http://www.cms.gov/Medicare/Coding/ICD10/index.html to learn more about the pending implementation.

ICD-10

“On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted, which said that the Secretary may not adopt ICD-10 prior to October 1, 2015. Accordingly, the U.S. Department of Health and Human Services expects to release an interim final rule in the near future that will include a new compliance date that would require the use of ICD-10 beginning October 1, 2015. The rule will also require HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.”
Resources

Cahaba GBA
www.cahabagba.com

CMS Website
www.cms.gov
General inquiries should be referred to the Provider Contact Center

For Jurisdiction 10 (AL, GA, TN providers):

877-567-7271

Questions related to electronic billing issues should be referred to the EDI Help Line:

866-582-3253
We value your opinion and appreciate your feedback and comments regarding today’s event.

Take a moment to complete the Online Evaluation.

Thank you for your participation!