CMS – New Place of Service Policy

Effective April 1, 2013, services paid under the Medicare Physician Fee Schedule have a new place of service (POS) policy.

The Medicare instructions state that the POS code to be used by the provider will be assigned as the:

- Same setting in which the beneficiary received the face-to-face service, or
- Where there is not face-to-face service, e.g., the professional component of diagnostic testing, laboratory or other services; the POS code will be the setting in which the beneficiary received the technical component (TC) of the service.

The two exceptions to this face-to-face rule are;

- The provider must use the POS code where the beneficiary is receiving care as in patient (code 21), or
- An outpatient code (code 22) of a hospital, regardless of where the beneficiary encounters face-to-face

The clarifications regarding global and professional component services are state in this article but you may read the complete POS policy instructions in The MLN Matters Bulletin.

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).

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.

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).