PLACE OF SERVICE

File Name: place_of_service
Origination: 6/2022
Last Review: 12/2022
Next Review: 12/2023

Description

A place of service code is a two-digit numeric character that is used on a professional claim to report where a service(s) was provided. The place of service code set list is maintained by The Centers for Medicare & Medicaid Services (CMS) and can be located in the CMS Place of Service List as cited in the Reference section of this policy.

Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) descriptions and coding guidelines may denote the most appropriate place of service (POS). In some cases, the descriptions or guidelines may define when a POS is considered inappropriate when reported by a physician or other health care professional. All claims with procedure codes are required to indicate a place of service on the claim line. According to the CPT manual, place of service (POS) should be specified and match the procedure code's description and/or guidelines for use.

Policy

Blue Cross Blue Shield North Carolina (Blue Cross NC) will reimburse places of service according to the criteria outlined in this policy.

Reimbursement Guidelines

Blue Cross NC requires the appropriate place of service to be reported for a claim to be eligible for reimbursement and can often be found within the CPT® or HCPCS code description or coding guidelines.

Blue Cross NC aligns with the CMS place of service code set listing and will maintain systems to remain up to date with any changes.

Blue Cross NC follows the instruction and guidance of code issuers, including but not limited to CPT®, HCPCS Level II, and ICD-10-CM.

For purposes of this policy, Blue Cross NC will not provide reimbursement for procedures codes reported with inappropriate places of service.

Clinical Social Work Services While Inpatient
Social worker services are included in the facility payment when performed on a member who is registered in an inpatient status and will not be eligible for separate reimbursement.

Durable Medical Equipment (DME)
DME must be billed in the place of service where the member intends to use it, not where it is dispensed.

Evaluation and Management (E/M) Services
Most E/M codes include the place where a service is to be rendered included within the code description. The E/M service will not be eligible for reimbursement if it is reported in a place of service that conflicts with the location included in the code description.

Home Health/Home Infusion
Home Health/Home Infusion procedures should be limited to the following place of service: School, Homeless shelter, Home, Assisted living facility, Group home, Temporary lodging, Custodial care facility, Intermediate care facility/individuals with intellectual disabilities and Residential substance abuse treatment facility. If performed in a home infusion therapy in infusion suite, the claim must be reported wth a modifier representing this. Additionally, home infusion/home therapy services are not eligible for separate reimbursement when a member is in an inpatient status, such as an inpatient hospital or skilled nursing facility.

Laboratory Services Billed by Physicians
The technical and professional components of a laboratory test are included in the payment to the facility in which the services were rendered, therefore, physicians will not be reimbursed separately except when the professional component is billed by a provider in onf of fhe following specialities: dermatology, genetics, hematology, laboratory, and pathology

Typically, the interpretation of a blood smear should be completed by a physician in an inpatient hospital or an independent laboratory. However, the interpretation of a blood smear in an office setting is only appropriate for a hematology-oncology physician.

Moderate Sedation
When moderate sedation services are performed by a second qualified provider, other than the provider performing the diagnostic or therapeutic service that the sedation supports, is only reimbursable in a facility place of service.

Mutually Exclusive Places of Service
The place of service code used should indicate the setting in which the patient received a face-to-face encounter or where the technical component of a service was rendered in the case of an interpretation. In the event, the member is registered as inpatient status, then the physician/practitioner/supplier providing the service needs to indicates as such, irregardless on where the actual face-to-face encounter occurred.

Services While Inpatient
Professional services billed in a Facility setting other than inpatient while a member is registered as an inpatient, are not reimbursable.

Supplies and DME in the Facility Setting
Medical and surgical supplies and DME are not reimbursable as professional services in the facility setting.

Rationale

According to code description and available coding guidelines, some codes should not be filed in some places of service.

Billing and Coding

Applicable codes are for reference only and may not be all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com.

Related policy

Bundling Guidelines

Evaluation and Management Services

Outpatient Code Editor (OCE) Edits

Pricing & Adjudication Principles

Status Codes

Supplies and Equipment

References

Healthcare Common Procedure Coding System

American Medical Association, *Current Procedural Terminology* (CPT®)

Centers for Medicare and Medicaid Services, National Physician Fee Schedule (NPFS)

Centers for Medicare & Medicaid Services, CMS Manual System, Medicare Claims Processing Manual 100-04, OPPS, and OCE

CMS Place of Service List, https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Provider Blue Book

History

6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022.** (eel)
12/31/2022	Routine Policy review. Alphabetized Reimbursement Guidelines, added language to clarify DME billing requirement for POS. Medical Director approved. (cjw)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing, and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.

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