Commercial Reimbursement Policy

Subject: **Place of Service – Professional**	
Policy Number: **C-09001**	Policy Section: **Coding**
Last Approval Date: **08/09/2024**	Effective Date: **10/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan requires the appropriate place of service code to be reported for a claim to be eligible for reimbursement. The appropriate setting for a procedure or service is identified by the following:

- CPT® or HCPCS Level II code description
- CPT coding guidelines

For new and revised codes and/or guidelines, the Health Plan will update the claims editing system to include a place of service restriction whenever the code definition or coding guideline specifies an appropriate place of service for reporting the code(s). In addition, the Health Plan

will conduct an annual review of surgical codes with an assigned place of service restriction and update the claims editing system when we determine that a place of service restriction is no longer applicable for a particular procedure. The Health Plan will also review new surgical procedure codes to determine if a place of service restriction is applicable.

Place of Service Defined Codes:

- When a place of service specific E/M is reported with a place of service that does not match the place of service identified for that code, the E/M service is not eligible for reimbursement.

There are a number of CPT and HCPCS codes that are specific to services provided in a home setting. If the services are reported by a professional provider with a place of service other than home setting, the service is not eligible for reimbursement.

- Services reported by a professional provider with a place of service School (03) will be eligible for non-office place of service reimbursement.

The following are considered included under the facility reimbursement and are not eligible for separate reimbursement when reported by a professional provider with a facility setting place of service code:

- Any medication even when reported with an unspecified code.
- Injection of dipyridamole per 10 mg, and radioelements for brachytherapy, as part of the technical portion of diagnostic imaging or treatment services.
- Vaccines and the administration of vaccines.
- Materials, supplies, or elements for enteral and parenteral therapy services represented by HCPCS “B” and “E” codes.

Note: The Health Plan considers evoked otoacoustic emissions screening, limited auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system, and distortion product evoked otoacoustic emissions limited evaluation performed in a facility setting to be included under the facility’s reimbursement. Therefore, when any of these hearing screening services are separately reported by a professional provider during the same timeframe of a member’s inpatient stay or any facility setting, they are considered to be duplicate of reimbursement and such services will not be eligible for separate reimbursement.

Related Coding

Code	Description
Coding Guidelines for Place of Service	Coding Guidelines for Place of Service

Policy History

08/06/2024	Review approved 08/06/2024 and effective 10/01/2024: • Removed *Place of Service (02) and (10)* from the Place of Service Defined Codes section and added to Virtual Visits-Professional and Facility policy (C-08002) • Removed *contrast materials, radiopharmaceutical materials* from the section for services considered included under the facility

	reimbursement and added to Diagnostic Radiopharmaceuticals & Contrast Materials- Professional and Facility (C-24001)
04/13/2022	Review approved: added Telehealth (10) place of service, effective 01/01/2022
07/29/2021	Review approved: updated language for place of service Telehealth (02) for office-based reimbursement
03/26/2021	Review approved and effective 03/26/2021: updated code list with new 2021 codes per CPT guidelines: 77416, 77422 and 92586 have been deleted and new codes added 92650, 92651, 92652, 92653; Reference and Related Policies sections have been updated
11/25/2020	Review approved and effective 11/25/2020
06/21/2019	Review approved and effective 01/01/2020; Policy language updated to stated that Telehealth (02) and School (03) to be reimbursed at the facility reimbursement when provided by a professional provider in a facility setting. Policy language consolidated and administrative changes made to the policy body. Place of service code restrictions removed and added to the coding section.
10/05/2018	Review approved: Updated language in section V. Additional Place of Service Restrictions h. Hearing Screenings. Added clarifying language for providers billing with place of service 15 – mobile unit
03/07/2017	Review approved: Update section V.a. for DME not eligible for reimbursement in SNF place of service exception **Exceptions for skilled nursing facility: • Hospital beds E0194, E0301, E0302, E0303, and E0304 Wound care items A6550, A7000, and daily rental of E2402
10/04/2016	Review approved: Section I b: add more defined language for the various places of service consider a home setting: schools (03), homeless shelter (04), home (12), assisted living facility (13), group home (14), and temporary lodging (16). Additional language updates for clarity without changes to the policy criteria.
05/03/2016	Review approved: Under section 1.d., adding urgent care facility (pos 20) as allowed pos for 99050 and 99051; aligns with After Hours policy update Removed reference to office POS in section V. “Additional Place of Service Restrictions, ” bullet “a,” and creating new bullet “b” that DME rental not allowed when reported with office (11) or urgent care facility (POS 20)
12/01/2015	Review approved Under section V. Additional Place of Service Restrictions adding: 1. e. The Health Plan considers the provision of any vaccine and the administration of such vaccines to be included under the facility’s reimbursement when the vaccines and administration are provided in a facility setting. Therefore, when a vaccine and the vaccine administration are reported by a professional provider with a facility setting place of service code, the vaccine and vaccine administration charges will not be eligible for separate reimbursement. 2. f. The Health Plan considers enteral and parenteral therapy to be included under the facility’s reimbursement when provided in a facility setting. Therefore, when these materials, supplies, or elements

	represented by HCPCS “B” and “E” codes are reported by a professional provider with a facility setting place of service the charges will not be eligible for reimbursement. Under bullet a. adding info for POS 19 “off campus- outpatient hospital” and updating language for POS 22 “on campus-outpatient hospital”
06/02/2015	Review Approved: 1) Pg. 2, was going to remove some of the “S” codes under section I.b. since these codes are now part of rule 25 as “always bundled” however, the Place of Service rule (#53) fires first (order 18) and rule 25 fires after place of service (order 23) 2) Updated language under section I. d. for codes 99050 and 99051 to advise the reader that do not identify specific holidays therefore no additional consideration is given to holidays outside the after-hours criteria 3) Pg. 3, section III, removing 77418 from the radiation treatment codes because this code was deleted from CPT 1/1/2015 4) Pg. 3, section V.a., clarify that DME rented or purchased in one of the settings identified will not be eligible for reimbursement (currently happens in the edit) Pg. 4, for the services identified as not allowed professional reimbursement when reported by a professional provider in a facility setting, consider the reimbursement part of the facility’s reimbursement and not make reference to the facility’s charge since most of these services are included in the facility’s per diem rate and should not speak to what a facility is charging for
06/03/2014	Revised: On page 4 add a bullet that radiopharmaceuticals reported by a professional provider in a facility setting will not be eligible for reimbursement: There are also minor language/punctuation updates. In bullet V. e., CPT code 92558 was relocated from line 3 to line 1 allowing the coding to be in numerical order within the paragraph.
05/06/2014	Revised: 1. On pg. 4, section V. d., this policy is being revised to add hearing test code 92587 (distortion product evoked otoacoustic emissions limited evaluation) is not eligible for reimbursement when reported with a facility Along with the substantive revision in V. d., there are additional language updates such as using “when” in place of “if” (for instance “when” an emergency room department visit is reported in an office setting… instead of “if” an emergency room…), spelling out durable medical equipment when noted the first time in the policy, and other non-substantive updates
02/04/2014	Review Approved: 1. Simple annual review Minor language/grammar/punctuation updates
02/05/2013	Revised: • Updated the word “verbiage” to “description” throughout the document • Updated “professional CMS-1500 form” to “Form CMS 1500 throughout the document • Under section 2—Correct Coding Guidelines, added reference to Injection and Infusion and Administration… policy

	• Under section 4—POS restrictions for inpatient only, spelled out inpatient hospital first and parenthetical (21) after description • Under section 5—Additional POS restrictions, added section indicating 92586 and 92558 are not eligible for reimbursement which performed in a facility setting; part of facility's reimbursement
09/11/2012	Review approved: Under section 5, pg. 3, added piece stating medication separately reported with facility place of service will not be eligible for separate reimbursement.
07/24/2012	Review approved: Add place of service office DME rental not eligible for reimbursement
07/10/2012	Review approved: Pg. 3: 5. Additional Place of Service restrictions Addition to first bullet: The Health Plan does not reimburse for DME when rented for use in an ambulatory surgical center or surgical suite setting (24), emergency room (23), hospital inpatient (21) or outpatient (22), or skilled nursing facility (31) (e.g., rental of compression devices, HCPCS codes E0673, E0675, and E0676, are not eligible for reimbursement when reported in a facility place of service).
02/10/2012	Review approved: 1) Grammatical updates 2) Coding #3—Place of Service restrictions for Radiation a) Treatment Delivery codes b) Second bullet added c) Coding table added for technical only component codes 3) Coding #4—coding updates Added Coding #5—Place of Service restriction for DME and Sleep Studies
11/02/2010	Review approved: under the Coding Section, "d." was added to the 1. Place of Service Defined Codes. This addition further emphasizes that there is a place of service restriction on CPT 99050 and 99051
07/06/2010	Revised: A 2nd bullet was added to give the example of radiation treatment codes 77401-77417 being technical codes not to be reported by a physician in a facility setting.
06/01/2010	Review approved: No policy statements were changed. However, some minor coding corrections were made. #1.b. CPT 94005 was removed as an example since many plans have this code as inclusive. #3 coding grid was updated to include the complete range 32440-32500 instead of just the indented codes of 32482-32484; and typo corrected-codes should be 32851-32854 (not 38251-38254)
06/24/2009	Review approved: exception codes for reporting by a physician in a facility setting were added to section #2
04/28/2009	Review approved: code range in Section #1 changed from 99341-99380 to 99341-99364 per POS sub-team
02/03/2009	Initial policy approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2024

Definitions

Place of Service Code	Two-digit numeric character that is used on a professional claim to report where a service(s) was rendered.
Home Setting	The Health Plan recognizes settings such as schools (03), homeless shelter (04), home (12), assisted living facility (13), group home (14), and temporary lodging (16) to be a home setting.
General Reimbursement Policy Definitions	

Related Policies and Materials

After-Hours, Emergency, and Miscellaneous E/M Services - Professional
Clinic Charges - Facility
Facility Guidelines for Claims Related to Professional Services- Facility
Injection and Infusion Administration and Related Services and Supplies - Professional
Office Place of Service - Professional
Sleep Studies and Related Bundled Services & Supplies - Professional

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.