CMS Provides New Guidance on Place of Service Coding

By Adrienne Dresevic, Esq. and Carey F. Kalmowitz, Esq., and Stephanie P. Ottenwess, Esq.

On February 3, 2012 the Centers for Medicare & Medicaid Services (CMS) issued the highly anticipated Transmittal 2407 which revises and clarifies the place of service (POS) coding instructions. The Transmittal directly affects radiologists and imaging centers as it provides new instructions on the interpretation or Professional Component (PC) and the Technical Component (TC) of diagnostic tests. Transmittal 2407 will become effective on April 1, 2012; its implementation date is set for April 2, 2012.

By way of background, a set of POS codes is maintained by CMS. Under Medicare, the proper POS code must be included on each claim made on the paper Form CMS-1500 or its electronic equivalent. When a POS code is created, CMS decides if the Medicare Physician Fee Schedule (MPFS) facility or non-facility payment rate should apply for the setting in question. Physicians and suppliers report the proper setting in which the services to the beneficiaries were provided by selecting the appropriate POS code from the CMS list. The Medicare Administrative Contractors (MACs) then make payments to the physicians and suppliers at the MPFS facility or non-facility rate which is appropriate for the POS code. Between CY2002 and CY2007, the Office of the Inspector General (OIG) consistently found that physicians and suppliers often selected the improper POS codes, especially for services provided in outpatient hospitals and in ambulatory surgical centers. In an attempt to fix this problem, the OIG called upon CMS to provide guidance to physicians, suppliers, and their billing agents regarding proper POS coding. As a result, a series of transmittals followed.

The Evolution of the POS Code Rule

Prior to Transmittal 2407, CMS guidance instructed physicians to use POS codes applicable to where the physician was physically located when providing the service. This guidance has now changed. Pursuant to CMS guidance set forth in Transmittal 2407, for all services paid under the MPFS, physicians, non-physician practitioners, and other suppliers will be required to use the POS code which corresponds to the setting in which the "the beneficiary received the face-to-face service." There are two exceptions to this face-to-face rule. A physician must use the POS code where the beneficiary is receiving care as a hospital inpatient (POS code 21) or an outpatient (POS code 22), regardless of where the beneficiary encounters the face-to-face service. This rule/exception was already in place for physician services (and certain independent laboratory services) provided to inpatient hospital beneficiaries but is now extended to services rendered to outpatient hospital beneficiaries. According to CMS, since face-to-face encounters are a requirement for the vast majority of services which are paid under the MPFS as well as anesthesia services, this general rule along with its exceptions will apply to nearly all services.

Specific POS Instructions for the PC and TC of Diagnostic Tests

Notably, CMS has specifically acknowledged, that there are instances where the face-to-face encounters are obviated, such as with diagnostic services that are comprised of a professional component and a technical component, which may be provided in different settings (e.g., the PC of a diagnostic test is provided from a distant site by a radiologist). In these cases, CMS instructs that the POS code chosen by a physician for the PC of a diagnostic service shall be based on the setting where the TC of the service was provided to the beneficiary. This is a significant change in radiology, as the place where the radiologist interprets a study is often times in a different location than where the TC of the study took place.

To illustrate the rule, CMS poses an example where the beneficiary receives a MRI at an outpatient hospital in the vicinity of his or her home. Consequently, this outpatient hospital submits a claim which corresponds to the TC portion of the MRI. Meanwhile, a physician provides the PC part of the MRI from his or her office location. In this situation, POS code 22 (ie, the outpatient hospital code) should be used on the physician's claim. This code is entered in Item 24B of the claim form. The presence of this code will indicate that that beneficiary received the face-to-face part of the MRI (ie, the TC) at the outpatient hospital. Importantly, the physician must still enter the zip code of his or her office location (ie, the location where the

interpretation took place) on the claim form (in Item 32) so that the proper payment locality and Geographic Practice Cost Index-adjusted payment for each service paid under the MPFS may be determined.

The issue this Transmittal did not address, and thus did not change, is the MAC jurisdiction issue - that the physical location where the physician renders the service determines which MAC has jurisdiction over the claim. Thus, in teleradiology arrangements in which a teleradiologist is providing a final read, claims for the PC portion of the study must be submitted to the MAC that has jurisdiction over the physical location where the interpreting teleradiologist is sitting. This continues to require the imaging center or radiology group that contracts with a radiologist interpreting studies remotely to enroll in the MAC jurisdiction where the remote physician is interpreting the study. In some teleradiology arrangements, this could mean the imaging center or radiology group will be enrolling in and submitting claims in several MAC jurisdictions.

Moving Forward

Transmittal 2407 provides much-needed guidance regarding POS coding, especially as it relates to the PC and TC portions of diagnostic tests. As the effective date of April 1, 2012 approaches, physicians, suppliers, and their billing agents need to familiarize themselves with the clarifications and new instructions provided by this CMS directive. As the publication does not resolve all anticipated issues relating to POS coding, including teleradiology and MAC jurisdiction, further guidance is needed from CMS. Until further guidance is received, however, the MAC jurisdiction for submitting claims will be determined by the physical locality of where the radiologist renders the interpretation.

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Commentary

News from Associated Sciences Consortium

By Donna Blakely MS, RT (R)(M)(CRA)

For the past three years, I have served as the AHRA liaison for the Associated Sciences Consortium. I have found that this liaison relationship had been very valuable for AHRA in working with our peer organizations and having our organization recognized at the RSNA Annual Meeting. During the most recent meeting I attended on January 30, 2012, we discussed the highlights of the Associated Sciences courses offered during the 2011 RSNA Annual Meeting and looked ahead to 2012's meeting this November.

The Associated Sciences Consortium is a working group representing professional societies in radiologic sciences, technology, and administration. At the 2011 RSNA, the Associated Sciences Consortium sponsored 10 courses. All courses were well attended and well received. RSNA Associate members have continued to rise with 94 Associate Members as of December 2011. There were 4,020 radiology support personnel who attended the 2011 RSNA.

During our call, ratings and attendance were reviewed for the following 2011 Associated Sciences courses:

• Implications for the Changing Face of Health Care: Aging and the Shift of Population
Attendance : 90
Speakers rated at 4.35 and 4.42 out of 5.0
• Implications for the Changing Face of Health Care: Delivery and Regulatory Impacts
Attendance: 173
Speakers rated at 4.39 and 4.55 out of 5.0.
•Changing the Score of Practice: Gaps and Overlaps
Attendance: 117
Speakers rated 4.3, 4.33, and 4.49 out of 5.0.
• Medical Imaging Radiation Exposure Origins, Consequences, and Control: Optimization of Radiation Dose
Attendance: 178
Speakers rated 4.41 and 4.11 out of 5.0.
• Ethics in the Era of Health Care Reform