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MEDICARE PLACE OF SERVICE CODING AND REPORTING

Implications for Radiology Practices

On April 1, 2013, CMS, the Centers for Medicare and Medicaid Services, plans to begin to enforce its rules for reporting the Place of Service (POS) code and the physical address of service (Service Facility Location) on claims paid under the Medicare Physician Fee Schedule. To this end, they have provided clarification of the rules in advance of the compliance date. In some cases, practices will no longer be allowed to use global billing for imaging center services. These rules may be a burden on radiology practices since, very often, the radiologist does not interpret the images in the same location where the patient had the examination. Radiology Information Systems are not usually set up to capture the reading site separately from the location where the patient's exam took place.

The changes to the rules can be summarized as follows:

Service Facility Location

- The use of Global Billing now depends on the location of the professional and technical component services as well as the relationship between the parties.
- When professional and technical components are billed separately, the Service Facility Location should reflect where the service was actually provided. In the case of a radiologist, this would be where the interpretation was completed.
- The fee schedule to be used for payment will depend on the actual location of the services, based on zip code. The fee schedule for the professional component may be different from that of the technical component.

Place of Service (POS) Code

- This generally follows the location where the patient's exam took place, even if the interpretation was performed remotely by teleradiology. This clarifies the general treatment that has been in place for some time.

Every radiology practice using teleradiology, whether they are hospital-based or have imaging centers, will have to consider whether some change to their data capture methods and payment level will be impacted by this rule, either positively or negatively. Only those who read their images at the same site as the patient exam will not need to concern themselves with the implication of the rule.

Global billing will no longer be available when images are read remotely and the physician providing the interpretation is in a different payment locality from the imaging center; the Professional Component (PC) will have to be billed separately from the Technical Component (TC). This will happen most often when the practice is large enough to span a wide area, but practices that are on the border of two payment localities will have to look carefully at their operations. It could also affect radiologists who work from home. See Table 1 to determine the type of billing to use and the address to be entered on the claim.

CMS has long been trying to capture more specific information about the location of services and has made several attempts to implement rules to do so. Their intent is to make payment at the fee schedule amount that is based on the geographic practice cost index (GPCI) where services are actually rendered. Thus, when the interpretation is performed in a different payment locality (geographic location) from the patient exam, each of those separate services will be paid at the fee schedule in effect for the site of service. In addition, CMS feels that more specific disclosure will assist in their verification that practices are in compliance with other rules such as the anti-kickback and the anti-markup provisions.

Global vs. Split Billing

Global billing is used when the interpreting physician is a part of the same billing entity as the imaging center (either as an employee or under direct contract) *and* when the physician's location while providing the interpretation is in the same payment locality. In this case, the address to be used is that of the imaging center alone, regardless of the physician's location when providing the interpretation.

However, if the interpretation takes place in a *different* payment locality, split PC/TC billing (attaching modifier -26 for the PC) must be used with the location of each component reported separately. The address of the physician's most common practice location is to be used. An unusual and infrequent location such as a hotel or other temporary location is *not* to be entered on claim forms. Interpretation from a temporary location will not change the billing method normally used for the physician's usual location.

See Table 1, below, for assistance with applying these rules.

Location of Physician (PC) Services

The physical address, including the zip code, where the radiologist provided the interpretation is to be entered on claims in Box 32 of CMS-1500 (or electronic equivalent). This may or may not be the same as the location where the patient's exam took place. The address entered in Box 32 will determine the fee schedule to be used based upon the payment locality of the zip code. Practices located near the border of payment localities should be aware of the payment levels in each in order to avoid unintended lower payments or to take advantage of higher payment levels by using teleradiology strategically.

Many radiologists interpret images from their homes, and the home address will have to be reported whenever separate PC billing is required. This can include hospital reads or imaging center reads if the home is in a different payment locality than the imaging center. An unusual or infrequent location such as a hotel or other vacation location is not to be entered on claim forms; instead, the address of the physician's most common practice location is to be used.

Place of Service Code Assignment

The Place of Service (POS) Code should reflect the place where the patient 'face-to-face' interaction occurred, regardless of where the reading was done. PC claims for hospital outpatient cases read by the radiologist from an imaging center would carry the POS code 22 for Outpatient Hospital because that is where the patient was seen, not code 11 for the radiologist's location.

An exception to the face-to-face rule is for inpatients of a hospital or other facility that are transported to an imaging center for an exam. In this case, the patient exam would be coded 21 (Inpatient Hospital), rather than code 11, for the office where the exam actually took place. The same would apply for a registered hospital outpatient if services were provided elsewhere.

The POS code is to be entered in Box 24 of CMS-1500 (or electronic equivalent). The most common codes for radiology services are:

Physician Office	POS code 11
Inpatient Hospital	POS code 21
Outpatient Hospital	POS code 22
Emergency Department	POS code 23
Ambulatory Surgery Center	POS code 24

Implementing These Rules

In order for practice management systems to accommodate the CMS policy, physicians will need to report the actual location of interpretations. Some have suggested that the location might be dictated into the radiologist's report, although this may not be an ideal solution. Other ideas for capturing the information include using the dictation system's station identifier or perhaps the PACS to feed the Radiology Information System (RIS). Regardless of how it gets there, the RIS will need to have a field for the data; and where applicable, the billing system (whether billing is performed in-house or outsourced) will need to determine whether a split or global bill is appropriate. Note that these rules apply *only* to Medicare billing, so changes will not be required for non-Medicare services unless a specific contract calls for adherence to Medicare policies. Accordingly, systems will have to provide for implementation of rules based on payer.

Those submitting claims for professional services rendered outside of the payment locality of their hospital or imaging centers will have to be enrolled with the Medicare carrier for that area and submit those claims separately to the appropriate carrier for payment. If the Medicare Administrative Contractor (MAC) is the same in both localities, the process should not be too difficult; however, this might not be the case if state lines are crossed. In order to complete enrollment, the MAC would most likely require documentation of licensure in their state, even though the general rule is that a physician must be licensed in the state where the patient exam takes place, regardless of where his or her interpretation is done.

Practices have until April 1, 2013 to assess how they may be impacted by these regulations and make any necessary adjustments.

Other action steps might include:

- Ascertain that POS coding is appropriate. In most cases, no changes will be required.
  - The POS Code in Box 24 might not necessarily match the service facility location in Box 32, whereas until now the two might have been linked.
- Determine the extent to which exams are read at sites other than where the patient encounter takes place.
  - If physicians work from their homes, determine if the home would qualify as a regular place of work.
- Identify the payment locality for each off-site location.
  - For each instance where the reading takes place in a different payment locality, determine the MAC for that locality.
  - When the MAC for the reading is different than the one for the imaging center, the practice will have to be enrolled and submit claims to that MAC.

- Check state licensure requirements to be sure all appropriate licenses have been obtained.
- Determine how the reading location will be captured in the RIS and billing systems.
- Devise a method to determine if separate billing will be required.
  - Software might have to be modified to provide split billing where previously global billing was used.

The official CMS document that contains these rules is Transmittal 2613/Change Request 7631 dated December 14, 2012. It can be found at http://www.cms.gov/regulations-and-guidance/guidance/transmittals/2012-transmittals-items/r2613cp.html.

TABLE 1: Payment Locality Reporting for Radiology Professional Services

Patient Face-to-Face Location	PC Entity vs. TC Entity	Radiologist Location	Type of Billing	Address (Zip Code) for PC
Hospital IP, OP, ER	Different	Hospital	Split PC/TC	Hospital
Hospital IP, OP, ER	Different	Off-site	Split PC/TC	Regular offsite reading location
Imaging Center	Different	Imaging Center	Split PC/TC	Imaging Center
Imaging Center	Different	Off-site	Split PC/TC	Regular offsite reading location
Imaging Center	Same	Imaging Center	Global	Imaging Center
Imaging Center	Same	Office in same payment locality	Global	Imaging Center
Imaging Center	Same	Office in different payment locality	Split PC/TC	Regular offsite reading location

- "Regular offsite reading location" includes any location where the radiologist regularly works, which could include his or her home.
- "Imaging Center" includes a physician office or ASC setting.
- A vacation hotel or other temporary location should not be reported; the address of the radiologist's regular work location should be reported in Box 32.