Place of Service Codes
Key to Compliant Billing

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Billing appropriately for services provided to oncology patients is not limited to the procedure codes themselves. In fact, key pieces of information on the claim submitted to the payer tell more of the patient story. One of these key components is the place of service (POS) code.

POS codes are 2-digit numeric characters reported on the professional component services claim; they identify the setting in which a service was provided to the patient. The national POS code set is maintained by the Centers for Medicare & Medicaid Services (CMS), but it was the 1996 Health Insurance Portability and Accountability Act (HIPAA) that outlined standards on protection of patient information and established guidelines for communication of POS codes.[1] HIPAA requirements, which went into effect October 16, 2003, apply to all covered payers and not just Medicare and Medicaid. Additionally, the Health Insurance Reform: Standards for Electronic Transactions final rule published August 17, 2000, established a standard for how to use POS codes to electronically communicate the place where services were provided to patients.[2]

The POS code is entered into box 24B of the CMS1500 claim form for services provided by the physician or another qualified health care professional. The POS code corresponds to the provider address that is credentialed with the payer and the location where services were delivered; the only exception is telehealth services as the POS, which may indicate the location of the patient relative to the qualified health care professional.

In addition to information about where the patient received services, the POS codes also contain information about payment rates. The Medicare Physician Fee Schedule establishes payment rates for professional services provided in the facility and nonfacility setting, and the POS code on the claims form identifies the appropriate payment rate. Facilities are locations such as hospitals (inpatient or outpatient), ambulatory surgical centers, and observation and emergency departments. Nonfacility settings are office-based settings (private practices) and independent diagnostic testing facilities.

When a practitioner provides services in the facility setting, the practice expense is lower than if services were provided in the nonfacility setting, this results in a lower professional payment rate. Payment is only established for the physician's work and fractions of practice and malpractice expenses. In the nonfacility setting—where physicians often own the practice, building, equipment, and supplies and directly employ staff—this additional overhead is factored into reimbursement, resulting in a higher professional payment rate.

It is possible that practitioners may provide services in multiple settings over a given date of service. When this situation occurs, separate claims for each POS must be submitted to the payer. It is also common for oncology patients to receive inpatient care in the hospital but receive medical or radiation oncology outpatient services in either the hospital outpatient department (outpatient provider-based department) or office-based setting. When this situation occurs, billers must remember that the hospital status follows the patient. So, for example, the claim billed to the payer for professional services when a patient is transported to the outpatient department or outpatient office setting will use the inpatient **POS code 21** for inpatient or **POS 31** for skilled nursing facility and not the outpatient POS code. Services provided are paid at the facility rate even though the patient may have been treated in the nonfacility office setting. This rate is based on how hospitals bill for inpatient services under the diagnostic-related group (DRG) with all provided services paid under a single payment per the assigned DRG. (Please note that the transfer agreement between the nonfacility setting and facility setting [inpatient hospital] should outline the payment for the technical services provided to the patient. This process is reviewed in Chapter 26 of the *Medicare Claims Processing Manual*.[3])

Additionally, since November 2, 2015, outpatient provider-based departments are recognized based upon 2 factors. The first is how long the outpatient provider-based department has been established with CMS; the second is how close the outpatient provider-based department is to the main building of the hospital. Any outpatient provider-based department within 250 yards of the main hospital building is considered an on campus-outpatient hospital **(POS 22)**. Outpatient provider-based departments more than 250 yards from the main hospital building are considered off campus-outpatient hospitals **(POS 19)**. In both settings, the practitioner is paid at the facility rate; however, payment for technical services may vary based on payment policy.

Telehealth POS codes also result in some reporting variances, and they may change again following the end of the waivers and extensions that are effective through December 31, 2024. For example, **POS 02** is recognized for Medicare claims adjudication when the patient is located

somewhere that is not their home. Typically, **POS 02** indicates an originating site, which is considered to be a facility setting; any practitioners providing services to patients in this location while physicians are in their office will be paid at the facility rate. **POS 10** identifies that patients were located in their homes when services were provided. Physicians providing services from their office location will report **POS 10**, and they will be reimbursed for services at the nonfacility rate.

Table 1 outlines some of the available POS codes most commonly used by oncology providers. The full list can be accessed on the CMS website.[4]

Ensuring accurate reporting of services, providers, diagnoses, quantities, dates of service, and place of service codes are all components of health care reimbursement. Each component is a layer that works in tandem to report the whole picture. This interconnection also serves as a reminder to billers and coders that sometimes the smallest action can impact the bottom line. Ensuring that staff responsible for billing and submitting claims are educated about the most up to date and current payment policies is key to compliance.

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Table 1. POS Codes Most Commonly Used by Oncology Practitioners

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy*	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective October 1, 2003.)
02	Telehealth provided other than in patient's home	The location where health services and health-related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health-related services through telecommunication technology. (Effective January 1, 2017; description change effective January 1, 2022, and applicable for Medicare April 1, 2022.)
10	Telehealth provided in patient's home	The location where health services and health-related services are provided or received, through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health-related services through telecommunication technology. (Effective January 1, 2022; available to Medicare April 1, 2022.)
11	Office	Location, other than a hospital, skilled nursing facility, military treatment facility, community health center, State or local public health clinic, or intermediate care facility, where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
13	Assisted living facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (Effective October 1, 2003.)
19	Off campus-outpatient hospital	A portion of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016.)
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (Effective January 1, 2003.)

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Place of Service Code(s)	Place of Service Name	Place of Service Description
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On campus-outpatient hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016.)
23	Emergency room-hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than individuals with intellectual disabilities.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

*Revised; effective October 1, 2005

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