



New Place of Service Rule Effective April 1, 2012

On February 3rd, 2012, CMS revised and clarified its place of service (POS) coding rules under the Medicare Claims Processing Manual. These rules, effective April 1, 2012, apply to all services paid under the Medicare Physician Fee Schedule (MPFS). Most specifically, POS coding by independent labs and multispecialty providers will undergo changes.

Many **independent labs and multispecialty providers** currently report POS 81 on basically every claim. Under these new rules, POS 81 will become, for the most part, unused. The new rule for pathologists and independent labs will require that POS be reported based on the physical location of the patient at the time the tissue, fluid, blood, or other lab specimen was obtained.

Example 1: The Professional Component (PC) and Technical Component (TC), or global service, for the pathologic examination of a tissue biopsy is reported with POS 21; if the biopsy was taken during an inpatient stay.

Example 2: The PC, TC or global service for the pathological examination of a tissue biopsy performed at a hospital on an outpatient basis, POS 22 must be reported.

Example 3: The PC, TC or global service for the pathological examination of a biopsy is performed at a private physicians office, report POS 11 (i.e. dermatology or urology office).

Example 4: Report POS 24 (ambulatory surgery center) when applicable. Payment issues linked to this POS have been an issue with some practices in the past, so special attention to these cases should be given to ensure denials do not become an issue once these rules have come into effect.

These new rules should have little or no effect on **hospital-based pathologists**, who have traditionally reported POS 21 for inpatients, POS 22 for hospital outpatients and POS 11 for non-hospital patient specimen (under all billing arrangements with referring offices).

In the same transmittal (Transmittal 2407), CMS also clarified how to fill out box 32 (service facility location information) of the hardcopy CMS-1500 form or electronic equivalent. The transmittal states, box 32 is to be populated with the address and zip code of the site where the service being billed was performed. For example, a tissue sample from a physician office that is processed and examined at a hospital would be billed by the pathologist showing the address of the hospital shown in box 32. As a rule of thumb, the address in box 32 will correspond with the CLIA number reported in box 23 of the same form. This clarification is important as it has been the source of debate over the years and has now been put to rest.

APS will continue to monitor these rules as they become available and apply all updates to our system to help ensure our clients see no disruption of payments. If you have any questions, please feel free to contact your Practice Manager.