Dermatology Coding Alert

Place of Service Codes: Know Your Place, and Keep POS Codes in Line

Make sure you're up to speed on the new and updated codes introduced Jan. 1.

Since Jan. 1, your dermatology practice should have been using one new and one updated place-of-service (POS) code for outpatient services. Now you need to make sure you're up to speed on why and how the change will impact your dermatology pay.

Crucial: CMS made the POS code change to avoid overpaying for services provided at off-campus hospital-based or provider-based clinics. Let us walk you through CMS's logic for the change, and more importantly, how you should use the updated POS code set when billing Medicare for your services.

The official new and revised POS definitions are:

- POS 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.
- POS 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.

Focus on Medicare Instruction

According to Change Request (CR) 9231 to the Medicare Claims Processing Manual, CMS wants you to use POS 19 for claims at off-campus hospital-based or provider-based clinics.

Here's why: "Congress passed H.R. 1314, the Bipartisan Budget Act of 2015, [in which] Section 603 addresses a reduction in payment for 'new' off campus provider-based clinics," explains **Duane C. Abbey, PhD,** president of Abbey and Abbey Consultants Inc., in Ames, Iowa.

Problem: Some physicians had been billing a non-facility POS code such as 11 (Office) for off-campus clinics instead of using outpatient POS 22, which was defined as "outpatient hospital" before the recent revision to add the qualifier, "on-campus."

Remember: The Medicare Physician Fee Schedule (MPFS) values services at a "facility" rate for hospital and Skilled Nursing Facility (SNF) patients, and a "non-facility" rate for settings such as physician offices. The non-facility rate typically pays more, to compensate you for overhead costs that you don't have to pay when the physician performs the service in a facility (because the facility covers those costs). CMS and the OIG have expressed concern that claims mischaracterizing POS as non-facility result in significant overpayment for physician Medicare services.

For instance: You'll see a difference in the facility and non-facility rate for the following biopsy codes (2016 MPFS National amount, conversion factor CF 35.8043):

- 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion) facility rate $ 50.13, non-facility rate $104.55
- 11101 (... each separate/additional lesion [List separately in addition to code for primary procedure]) facility rate $25.78, non-facility rate $33.30

Understand 'Off-Campus' to Master POS Coding

In order to report POS 19 and 22, you'll need to get a grip on the official definition of off-campus.

The basics: According to CMS, a campus is the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus.

"As of Jan. 1, you should use the current POS code 22 exclusively for services rendered in outpatient settings on the campus of the main hospital, such as outpatient clinics," says **Michael Granovsky, MD, FACEP, CPC**, president of LogixHealth, a national coding and billing company based in Bedford, Mass.

Key: CMS states that POS code 19 will follow the same payment policies as the current POS code 22, including the three-day rule. That rule states that services provided to patients at wholly-owned physician practices that occur within three days of a hospital admission are considered bundled into the payment for the admission, notes Granovsky.