Part B Insider (Multispecialty) Coding Alert

Medicare Policy Updates: CMS Knows You're Confused About POS Rules

Agency creates FAQs on the topic which prompt even more questions.

When CMS issued Transmittal 2679 on April 1, the agency was aiming to clarify place of service coding instruction. However, the change request (numbered 7631) only created confusion about how to report the place of service (POS) in certain scenarios, and CMS decided to take action.

"The place of service change request 7631 that went into effect on April 1 prompted a lot of questions, so we posted some frequently-asked questions on the CMS website," said CMS's **Chris Ritter** during a June 4 Open Door Forum.

The FAQs, although nine pages long (available at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQs-CR7631-4-25-13.pdf), unfortunately don't answer all queries that practices have, and many callers to the forum expressed frustration with the vague answers on the document.

For example, the FAQs pose the common question of how to bill the technical component of an IDTF service in a state that's different from where the professional component was furnished, and the answer on the document states that local MACs should give advice on this topic, but that "CMS is developing national enrollment requirements for situations where telehealth, teleradiology, and other services cross MAC jurisdictions."

This answer was disappointing for a number of practices who are seeking firm national guidance on this topic, and one of them said as much on the call. After the caller asked whether CMS has a timeline of when this national policy will materialize, a CMS rep said that the agency hopes to have it ready within the next few months, but that it's currently in process with the agency.

PTs Must Change Gear

Another caller to the forum noted that many therapists have been billing functional limitation reporting codes since January 1, which was when the testing period for this initiative began, even though the codes won't be required until July 1. The caller asked what will happen when a patient is already being treated as part of the testing period and will continue after July 1 – should the therapist continue on with the G codes he has been reporting, or must he start anew as if he's billing the G codes for the first time?

A CMS rep responded that an MLN Matters article on this topic is forthcoming, but for a patient already being treated, the functional reporting will have to begin as a new episode of care as of July 1, even if you've been using the G codes (such as G8978, Walking and moving around functional limitation...). Effective July 1, you'll have to start out as by reporting an initial evaluation code and submit the patient's goals and status as of July 1. "We realize that that's a little bit of a burden for those who have been doing the reporting, but it was a necessity for us to have the testing period and we do believe the testing period was important for many therapists," the CMS rep added.