Getting the Place of Service Right

It's important to use the correct POS.

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When seeing most patients in a nursing facility, practitioners must determine if the patient is under a long-term Medicare Part B stay or a Part A skilled nursing facility stay. The reason this determination must be made is that it changes the place of service code on the claim form. If the patient is under a long-term Part B stay, Place of Service 32 must be used on the claim form. If the patient is under a Part A skilled nursing facility stay, Place of Service 31 must be used on the form.

Place of Service[1]

Place of Service 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.

Place of Service 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.

A skilled nursing facility stay for Medicare beneficiaries is typically an inpatient rehabilitation stay following a qualifying inpatient hospital stay that was at least 3 days. Skilled nursing facility stays can normally be a maximum of only 100 days. Coverage for a skilled nursing facility stay typically requires one or more of: intensive rehabilitation, continued medical supervision, or coordinated care from doctors and therapists working together.

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In order to use the correct place of service code on a claim form, practitioners who see patients in a nursing facility must determine if the patient is in the facility under a long-term Medicare Part B stay or a Part A skilled nursing facility stay. This can be difficult because, in many cases, there are patients in the same building under these different admission types. There may even be two patients in the same hallway or in the same room as each other under these different admission types. Providers can make this determination by communicating with facility administrators.

Additionally, some third-party payers have online portals which providers can use to determine the admission status of patients in these types of facilities. APMA members can find links to some of these portals at APMA.org/RFCPOS.

It is the provider's responsibility to use the correct place of service codes on claim forms. Claims for services with Place of Service 32 typically have higher reimbursement associated with them than claims for the exact same services submitted with Place of Service 31. This can be frustrating for providers because, in many cases of Place of Service 31 versus Place of Service 32, providers are providing the same service that requires the exact same time, work, risk, instrumentation, thought intensity, and materials, but because the patient may have been in the building for a different number of days, the reimbursement is less.

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In addition to different fee schedules based on Place of Service 31 versus Place of Service 32, some services that are payable under Place of Service 32 are not payable under Place of Service 31. When a Medicare beneficiary is admitted to a Part A skilled nursing facility, (POS 31), there is a list of services that are separately payable to physicians. This is a CMS document titled "Part A Stay (Physician Services)." This can be thought of as the "covered-when-in-a-SNF" list. Some services are excluded from this "covered-when-in-a-SNF list" because payment for that service is considered to be included in the bundled skilled nursing facility payment that the facility receives.

Continued on page 38

Place of Service *(from page 37)*

In the Balanced Budget Act of 1997, Congress mandated that payment for the majority of services provided to Medicare beneficiaries in a Medicare-covered skilled nursing facility stay be included in a bundled prospective payment made through the Part A Medicare Administrative Contractor (MAC) to the skilled nursing facility. These bundled services have to be submitted by the skilled nursing facility to the Part A MAC in a consolidated bill.

Most services commonly performed by podiatrists do not fall under this bundled payment and are included in the "covered-when-in-a-SNF list." Evaluation and management services are on that list. Nail trimming and debridement services are on that list. Callus paring codes are on that list. Some services that podiatrists commonly provide that are ***not*** on this list (meaning they are not payable to physicians while the patient is under a Part A skilled nursing facility stay) include the technical component of radiology, certain durable medical equipment, and the service described by CPT® 97597.

If a patient is under a Part A skilled nursing facility stay, all of this applies regardless of where the patient is seen. That means if a patient is admitted under a Part A skilled nursing facility stay and is transported to a provider's private office, all of this still applies. Therefore, if a patient is transported to a private office from a nursing facility, the provider may want to communicate with that facility to determine if the patient is under a long-term Medicare Part B stay or a Part A skilled nursing facility stay.

A recent Medicare recoupment has drawn more attention to this issue. This recoupment dealt with Medicare taking back money that was inappropriately paid because claims were submitted with Place of Service 32 when they should have been submitted with Place of Service 31. This is happening to many providers in different parts of the country who made the same error. Everything that is shared herein about differentiating Place of Service 32 versus Place of Service 31 has been a long-standing guideline that has not changed recently. The enforcement is what has changed. The Office of the Inspector General explains this recoupment here: https://oig.hhs.gov/oas/reports/region4/42104084.asp **PM**

Reference

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