Professional Pricing Policy

Subject: **Place of Service**	
Policy Number: HLCP-0012	Policy Section: **Coding**
Last Approval Date: September 1, 2020	Effective Date: October 17, 2020

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

HealthLink requires the appropriate place of service code to be reported for a claim to bepriced and/or adjudicated. The appropriate setting for a procedure or service is identified by the following:

- the *Current Procedural Terminology* (CPT®') or Healthcare Common Procedure Coding System (HCPCS Level II) code description
- the CPT coding guidelines

For new and revised codes and/or guidelines, HealthLink will update the claims editing system to include a place of service restriction whenever the code definition or coding guideline specifies an appropriate place of service for reporting the code(s). In addition, HealthLink will conduct an annual review of surgical codes with an assigned place of service restriction and update the claims editing system when we determine that a place of service restriction is no longer applicable for a particular procedure. HealthLink will also review new surgical procedure codes to determine if a place of service restriction is applicable.

Place of Service Defined Codes:

- When a place of service specific E/M is reported with a place of service that does not match the place of service identified for that code, the E/M service is not allowed.
- There are a number of CPT and HCPCS codes that are specific to services provided in a home setting. If the services are reported by a professional provider with a place of service other than home setting, the service is not allowed.
- Services reported by a professional provider with a place of service Telehealth (02) or School (03) will be eligible for non-office place of service allowance.

The following are considered included under the facility allowance and are not separately allowed when reported by a professional provider with a facility setting place of service code:

- Any medication even when reported with an unspecified code.
- Contrast materials, radiopharmaceutical materials, injection of dipyridamole per 10 mg, and radioelements for brachytherapy, as part of the technical portion of diagnostic imaging or treatment services.
- Vaccines and the administration of vaccines.
- Materials, supplies, or elements for enteral and parenteral therapy services represented by HCPCS “B” and “E” codes.

NOTE: HealthLink considers evoked otoacoustic emissions screening, limited auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system, and distortion product evoked otoacoustic emissions limited evaluation performed in a facility setting to be included under the facility’s allowance. Therefore, when any of these hearing screening services are separately reported by a professional provider during the same timeframe of a member’s inpatient stay or any facility setting, they are considered duplicate and such services will not be separately allowed.

Related Coding

Code	Description	Comments
A0021-A0999	Transportation and Ambulance Services	Requires a POS 41 (land ambulance) or 42 (air or water ambulance) to be allowed
S0207-S0208	Transportation and Ambulance Services	Requires a POS 41 (land ambulance) or 42 (air or water ambulance) to be allowed
92558	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation with interpretation and report	Not allowed when reported by a professional provider with a facility place of service.
92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited	Not allowed when reported by a professional provider with a facility place of service.
92587	Distortion product evoked otoacoustic emissions; limited evaluation or transient evoked otoacoustic emissions, with interpretation and report	Not allowed when reported by a professional provider with a facility place of service.
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service	Requires a POS 11 (office) or 20 (urgent care facility to be allowed
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service	Requires a POS 11 (office) or 20 (urgent care facility to be allowed
77401-77412	Radiation treatment delivery services	Not allowed when reported by a professional provider with a facility place of service.
77417	Therapeutic radiology port image(s)	Not allowed when reported by a professional provider with a facility place of service.
77371-77373	Stereotactic radiation services	Not allowed when reported by a professional provider with a facility place of service.

Code	Description	Comments
77423-77425	Neutron Beam Treatment Delivery	Not allowed when reported by a professional provider with a facility place of service.
77520-77525	Proton Beam Treatment Delivery	Not allowed when reported by a professional provider with a facility place of service.
95807-95811	Attended polysomnography with/or without sleep staging	Not allowed when reported in a home setting

Exemptions

Definitions

Place of Service Code	Two-digit numeric character that is used on a professional claim to report where a service(s) was rendered.
Home Setting	The HealthLink recognizes settings such as schools (03), homeless shelter (04), home (12), assisted living facility (13), group home (14), and temporary lodging (16) to be a home setting.
General Professional Pricing Policy Definitions	

Related Policies and Materials

Sleep Studies and Related Bundled Services & Supplies

References and Research Materials

This policy has been developed through consideration of the following

- CMS
- American Medical Association (AMA) Current Procedural Terminology (CPT)

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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