

Transparency Policy: Place of Service Mismatch

Reference Number: CC.PP.063

Product Types: ALL

Effective Date: 09/01/2018

Last Review Date: 11/30/2021

[Coding Implications](#)
[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Policy Overview

The health plan administers edits based on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) descriptions and guidelines which are published by the American Medical Association (AMA). These prepay claims edits are utilized for professional and outpatient facility claims, auditing for potential coding errors.

The purpose of this policy is to identify instances in which a procedure code is billed with an inappropriate place of service per CPT/HCPCS guidelines. For some CPT and HCPCS codes, criteria are included for where these services may be performed. According to the CPT manual, place of service (POS) should be specified and match the procedure code's description and/or guidelines for use. The edit takes AMA, CMS, and state guidelines into consideration to ensure accurate reimbursement for services provided within each individual health plan.

Application

1. Physician and Non-physician Practitioner Services
2. Outpatient Institutional Claims

Reimbursement

Procedure codes reported with an inappropriate place of service will be denied on a prepayment basis through claims edits applied by code auditing software.

Any procedure code which has been reported appropriately per the guidelines in this transparency policy remains subject to all other applicable reimbursement policies and guidelines.

Definitions

Place of Service: A numerical code on a claim indicating the entity where service(s) were rendered.

Prepayment Claims Edit: Edit applied to one or more claim lines during the adjudication process prior to payment, based on the most likely clinical scenario in accordance with all applicable coding guidelines.

References

1. American Medical Association, *Current Procedural Terminology (CPT)*®, 2021
2. American Medical Association, *HCPCS Level II*, 2021
3. Centers for Medicare and Medicaid Services (CMS) manuals and publications
4. Individual state Medicaid regulations, manuals and fee schedules

Revision History	
09/01/2018	Policy created
09/01/2019	Conducted Review
11/01/2019	Annual Review completed
11/01/2020	Annual Review completed
11/30/2021	Annual review completed; no major updates required

Important Reminder

For the purposes of this payment policy, “Health Plan” means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan’s affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

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TRANSPARENCY POLICY

Place of Service Mismatch

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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