Understanding the Billing Requirements for Professional Services in a Facility

CMS requires hospitals to inform physicians/practitioners that when treating patients in a hospital-based department of their hospital that their services are required to be billed with the appropriate "place-of-service" code so that correct physician/practitioner payment can be determined by the Medicare Part B Carrier. The following information is being provided as part of the hospital's demonstration that it is complying with the requirement, as stated in the CMS provider-based regulations, 42 *CFR* 413.65(g)(2).

Medicare Part B pays for services by physicians to Medicare beneficiaries. These services include medical and surgical procedures and other services such as office visits and medical consultations. Although physicians routinely perform many of these services in a facility setting such as a hospital, skilled nursing facility, or community mental health center, certain of the same services may also be performed in non-facility settings, such as a physician's office. To account for the increased practice expense incurred by physicians in their offices, Medicare reimburses a higher amount for services performed in this setting.

Physicians are paid for services based on the Medicare Physician Fee Schedule. The Centers for Medicare & Medicaid Services (CMS) established relative value units (RVUs) for physician work, practice expense and malpractice insurance. Each RVU has a corresponding geographic practice cost index (GPCI) based on the geographical location of where the service is performed. To calculate the physician payment, each of the RVUs is multiplied by the appropriate GPCI and then the sum of these products is then multiplied by the nationally uniform conversion factor to determine the payment.

For certain services, Medicare has established two differential RVUs for practice expense to compensate physicians for the cost differences that result from performing a service in a facility as opposed to a non-facility setting. Physicians are required to identify the place of service on the health insurance claim form submitted to Medicare Part B Carriers for payment. The "place of service" code is located at field 24(b) of the CMS 1500 claim form. The Carrier will pay the physician for the professional component of services provided through the appropriate RVU facility or non-facility fee schedule rate based upon the place of service code. Certain services will be impacted by the place of service codes "21", "22" or "23" as they indicate the physician rendered the care to a patient of the hospital and that the professional component will be reimbursed at the lower RVU facility rate. The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform a Medicare service at facilities.

Physicians/practitioners must submit a claim to the Medicare Part B Carrier on CMS form 1500 for the professional services rendered to the patients in a hospital facility with the correct "place of service" code in order for the Carrier to pay the physician/practitioner appropriately. The following "place of service" codes are required when care is rendered in a hospital setting:

- Place of service code **"22"** denotes to the Carrier that the service was provided to a beneficiary who is an **outpatient of a hospital**
- Place of service code **"21"** denotes to the Carrier that the service was provided to a beneficiary who is an **inpatient of a hospital**.
- Place of service code **"23"** denoted to the Carrier that the service was provided to a patient in the **emergency department of a hospital**.

Place of service code "11" denotes to the Carrier that the service was provided to a beneficiary not registered as a patient of a hospital. (Place of Service Code "11" is never used when services are provided to hospital Medicare patients by the physician.)

Additionally, for certain services/procedures performed at the hospital or hospital-based clinic, the physician will be required to bill the Carrier with the modifier "26" to indicate they are only billing for the professional component (i.e., supervision or interpretation). For these services, the physician must not bill the Carrier "globally" or use the "TC" modifier for services rendered to either inpatients or outpatients of a hospital.

For additional information, refer to Chapter 26, Completing and Processing Form CMS-1500 Data Set, of the *Medicare Claims Processing Manual*.