AETNA BETTER HEALTH® of Illinois Policy

Policy Name:	Place of Service Policy	Page:	1 of 4
Department:	Medical Payment Policy	Policy Number:	XXXX.XX
Subsection:		Effective Date:	11/1/2023
Applies to:	■ Medicaid Health Plans		

PURPOSE: This policy provides guidance for POS Codes

STATEMENT OF OBJECTIVE: the policies below are based on CMS Guidelines

DEFINITIONS:

Aetna Better Health of Illinois	A subsidiary of CVS Health Corporation, Medicaid subsidiary that provides plan management and other administrative services for the Louisiana Medicaid program.
The American Medical Association (AMA)	A professional group that publishes research to advance public health and advocates for the interests of registered physician-members.
Current Procedural Terminology (CPT)	A medical code set maintained by the American Medical Association through the CPT Editorial Panel. The CPT code set (copyright protected by the AMA) describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.
Healthcare Common Procedure Coding System (HCPCS)	Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the level II HCPCS codes were established for submitting claims for these items.
Illinois Department of Health Care and Family Services (HFS)	The Department of Healthcare and Family Services administers health insurance programs for children, pregnant women, and adults who are residents of Illinois.
Medicare (CMS)	Medicare is a health insurance program for: people age sixty-five (65) or older, people under age sixty-five (65) with certain disabilities, and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Place of Service Policy	Place of Service (POS) Policy is a rule that specifies a certain CPT or HCPC codes can be billed when carried out at a particular location, guaranteeing accurate coding and reimbursement for medical services based on location were rendered.
Physician Fee Schedule Non-Facility NA Indicator	"Non-Facility NA" indicator signifies a services that is rarely or almost never provided in a non-facility setting.

REIMBURSEMENT GUIDELINES:

Physician Fee Schedule Non-Facility NA Indicator

- According to our policy, which is based on CMS Policy, some procedures or services are not appropriate in an office setting. Therefore, it is inappropriate to bill for these procedures or services when the place of service is an office (POS 11).

Mutually Exclusive Places of Service-

- According to our policy, which is based on CMS Policy, the place of service code used should indicate the setting in which the patient received a face-to-face encounter or where the technical component of a service was rendered, in the case of an interpretation. However, when a patient is in a registered inpatient status, all services billed by all providers should reflect and acknowledge the patient's inpatient status. When a physician/practitioner/supplier furnishes services to a registered inpatient, payment is made under the Medicare Physician Fee Schedule at the facility rate. A physician/practitioner/supplier furnishing services to a patient who is a registered inpatient shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter.

LEGAL/CONTRACT REFERENCE:

- Federal and state laws, rules, and regulations concerning the practice of pharmacy, third party administration, Medicaid laws, rules, and regulations
- Applicable federal and state laws, regulations, and directives regarding the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])

FOCUS/DISPOSITION:

Responsibilities

The chief medical officer (CMO) and chief operating officer (COO) are responsible for review and implementation based upon state and federal regulation. Aetna Medicaid Administrators LLC applies editing rules as implemented by NCCI and AMA standards. Editing may also be developed based upon recommendations for specialty societies.

OPERATING PROTOCOL:

Systems

- Business application systems

Measurement

- Edit Accuracy
- Edit Application
- Overturn of Adjustment Rates

Reporting

- Aetna Medicaid - Cotiviti Healthcare Monthly Performance Summary to plan leadership
- Claim Check Monthly Summary to health plans

INTER-/INTRADEPENDENCIES:

Internal

- Medical Payment Policy
- Payment Integrity Center of Excellence, Service Operations (PIAB)

- Chief Medical Officer
- Chief Operating Officer
- Claims
- Finance
- Medical Management
- Special Investigations Unit

External

- Clinical Editing Vendors
- Practitioners
- Providers
- Regulatory Departments
- Vendors
- Aetna Better Health

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Review/Revision History	
Revised	08/27/2025