



BILLING POLICY No. 050

DURABLE MEDICAL EQUIPMENT (DME) PLACE OF SERVICE (POS)

Effective date: Jan. 1, 2025

Review dates: 2/2025

Date of origin: Oct. 11, 2024

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

Place of service (POS) is defined as a two-digit number used to report where a service was provided on a professional claim. This list is maintained by the Centers of Medicare and Medicaid Services (CMS).

POLICY SPECIFIC INFORMATION

Durable Medical Equipment (DME)

DME claims should be coded with the POS where the member will primarily use the DME item. See list of appropriate DME POS as per our DME MAC. (See Resources below for more information.)

- 01 Pharmacy
- 04 Homeless Shelter
- 12 Home
- 13 Assisted Living Facility
- 14 Group Home
- 16 Temporary Lodging
- 27 Outreach Site/Street
- 33 Custodial Care Facility
- 54 Intermediate Care Facility/Individuals with Intellectual Disabilities
- 55 Residential Substance Abuse Treatment Facility
- 56 Psychiatric Residential Treatment Center
- 65 End Stage Renal Disease Treatment Facility (valid POS for Parenteral Nutritional Therapy)

RESOURCES

- [CGS Supplier Manual](#)
- [CMS Place of Service Codes](#)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 14, 2025	Added "Disclaimer" section