Priority Health	BILLING POLICY No. 050

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

Effective date: Jan. 1, 2025 **Date of origin: Oct. 11, 2024**	**Review dates: 2/2025, 4/2025**

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).

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

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

Proof of delivery

Proof of delivery and documentation is necessary to support compliance for payment purposes. It is required that suppliers of DMEPOS maintain proof of delivery for items they provide to patients.

Coding specifics

Initial delivery:

There are three methods of delivering items of DMEPOS to beneficiaries:

- Supplier delivering directly to the patient or designee
- Supplier utilizing a delivery/shipping service to deliver items

- Delivery of items to a nursing facility on behalf of the patient

An example of proof of delivery to a patient is having a signed delivery slip that includes:

- The patient's name and address
- The quantity delivered
- A detailed description of the item being delivered
- The brand name
- The serial number
- Date delivered and patient or designee signature

The date of signature on the delivery slip must be the date that the DMEPOS item was received by the patient or designee.

If the supplier utilizes a delivery/shipping service, examples of proof of delivery would include:

- The delivery service's tracking slip
- The patient's name
- The supplier's shipping invoice.
- The supplier's records should include the delivery service's package identification number.
- The delivery service's tracking slip should reference each individual package, the delivery address, the package identification number given by the delivery service, and the date delivered.

If the supplier utilizes a return postage-paid delivery invoice from the patient or designee as a form of proof of delivery, proof of delivery would include:

- The descriptive information concerning the DMEPOS item (i.e., the patient's name, the quantity, detailed description, brand name, and serial number)
- The required signatures from either the patient or the beneficiary's designee on the invoice

If the supplier delivers to a nursing facility on behalf of the patient, proof of delivery would include:

- Documentation demonstrating delivery of item(s) to facility by supplier or delivery entity; and,
- Documentation from nursing facility demonstrating receipt and/or beneficiary usage of item(s). Quantities delivered and used by the beneficiary must justify quantity billed

A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two days prior to the patient's discharge to their home.

The supplier should bill the date of service on the claim as the date of discharge and should use the Place of Service (POS) as 12 (Patient's Home). The item must be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.

Documentation requirements
Proof of delivery documentation must be maintained for 7 years starting from the date of service.

Definitions

- **Designee**: Any person who can sign and accept the delivery of durable medical equipment on behalf of the beneficiary."

RESOURCES

- CGS Supplier Manual
- CMS Place of Service Codes

- SE19003
- Medicare
- Proof of Delivery - JD DME - Noridian

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, HCPCPS, 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
Apr. 15, 2025	Added "Proof of delivery" section