



Place of Service

Reimbursement Policy ID: RPC.0063.7100

Recent review date: 02/2026

Next review date: 11/2027

AmeriHealth Caritas Delaware reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas Delaware may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

Place of service (POS) codes are two-digit numeric characters that describe where a service was rendered. The POS code list is maintained by the Centers for Medicare & Medicaid Services (CMS). This code set serves as the national standard for the electronic transmission of professional health care claims under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Exceptions

N/A

Reimbursement Guidelines

AmeriHealth Caritas Delaware will reimburse for eligible services that are billed using Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) when submitted according to CPT or HCPCS code descriptions and/or guidelines. If indicated, services must be submitted with the corresponding POS as described by the submitted CPT code – for example, home visit E/M services (99341-99350) should be submitted with POS “12” (patient’s home).

In addition to CPT and HCPCS code descriptions, AmeriHealth Caritas Delaware uses the CMS National Physician Fee Schedule Relative Value File (NPFV RVU) indicators to make reimbursement determinations relative to POS. For example, the NPFV RVU file includes “Non-Facility NA” and “Facility NA” fields – indicating that the procedure is rarely or never performed in that setting. A value of “NA” in the Non-Facility NA field will result in a claim denial if the claim indicates the procedure was performed in the home setting, for example. AmeriHealth Caritas Delaware will not reimburse claims with CPT and/or HCPCS codes that include an NPFV RVU indicator of “NA” when reported.

Place of Service Physical, Occupational and Speech Therapy

Physical, occupational and speech therapy may not be reimbursed in a hospital outpatient setting with a place of service (POS) -22 unless medical necessity is present as determined by prior authorization. A hospital outpatient setting is a portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

In the absence of prior authorization to provide services in an outpatient hospital setting (POS 22), the following CPT service codes must be billed with POS -11.

| | |
|-------|---|
| 92507 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual |
| 92508 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more |
| 92521 | Evaluation of speech fluency, e.g., stuttering or fluttering |
| 92522 | Evaluation of speech sound production e.g., articulation, phonological process, apraxia, dysarthria |
| 92523 | - with evaluation of language, comprehensive and expression, e.g., expressive and receptive language |
| 92524 | Behavior and qualitative analysis of voice and resonance |
| 92526 | Treatment of swallowing dysfunction and/or oral function for feeding |
| 92607 | Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face, with the patient, first hour. |
| 92609 | Therapeutic services for the use of speech-generating device including programming and modification. |
| 92610 | Evaluation of oral and pharyngeal swallowing function |
| 96110 | Developmental screening (developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument. |
| 96112 | Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social memory and/or executive functions by standardized |

| | |
|-------|---|
| | developmental instruments when performed) by physician or qualified health care professional with interpretation and report, first hour. |
| 97012 | Application of a modality to 1 or more areas; hot or cold packs, mechanical traction |
| 97035 | Application of a modality to 1 or more areas; ultrasound, each 15 minutes |
| 97110 | Therapeutic procedures, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility. |
| 97112 | Therapeutic procedures, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture and/or proprioception for sitting and/or standing activities. |
| 97116 | Therapeutic procedures, 1 or more areas, each 15 minutes; gait training (includes stair climbing). |
| 97129 | Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning executive function, problem solving and/or pragmatic functioning) and compensatory strategies to manage the performance of an activating (e.g., managing time or schedules, initialing, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes. |
| 97140 | Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction); one or more regions, each 15 minutes. |
| 97150 | Therapeutic procedure(s) group, (2 or more individuals) |
| 97161 | A physical therapy evaluation, involving a brief history (no impacting comorbidities), examination of 1-2 body system elements (like strength/flexibility), stable patient presentation, low clinical decision-making, and usually 20 minutes face-to-face time with patient and/or family, used for straightforward cases like a simple ankle sprain or post-operative check. |
| 97162 | A moderate complexity physical therapy evaluation, typically involving 30 minutes of face-to-face time with the patient. It requires a history with 1-2 personal factors or comorbidities impacting the care plan, an examination of 3 or more elements of body structure and function using standardized tests, and a clinical presentation that is evolving or changing. The therapist uses moderate clinical decision-making to develop the treatment plan. |
| 97163 | A high-complexity physical therapy evaluation that includes a patient history of three or more comorbidities or personal factors, an examination with unstable and unpredictable characteristics, and a clinical decision-making process of high analytic complexity. This complexity can be due to the patient having multiple conditions, a condition like a stroke or spinal cord injury, or the need for significant task modification during the evaluation. Typically, 45 minutes of face-to-face time with the patient and family. |
| 97164 | A physical therapy re-evaluation, used when a patient's condition changes significantly, requiring a new assessment, history review with standardized tests, and a revised plan of care (POC) with functional outcomes, typically involving around 20 minutes face-to-face. |
| 97165 | A low complexity occupational therapy evaluation, involving an occupational profile, brief medical/therapy history review (1-3 deficits identified), assessment for 1-3 performance deficits (physical, cognitive, psychosocial), and clinical decision-making leading to a limited treatment plan, used when minimal modifications are needed for assessment. |
| 97166 | An occupational therapy evaluation of moderate complexity, involving a thorough occupational profile, expanded medical/therapy history, identifying 3-5 performance deficits (physical, cognitive, psychosocial), and moderate clinical decision-making, typically taking about 45 minutes face-to-face with the patient. |
| 97167 | An occupational therapy evaluation, high complexity, typically lasting around 60 minutes. This is used when a patient's occupational performance is significantly impacted by a complex medical history and/or comorbidities, requiring a thorough occupational profile, review of extensive medical/therapy records, and identification of five or more |

| | |
|-------|--|
| | performance deficits. The clinical decision-making involved is of high analytic complexity, with multiple treatment options needing to be considered, and the assessment may require significant modification or assistance for the patient to complete. |
| 97168 | An occupational therapy re-evaluation of an established plan of care. It is used when there is a significant change in a patient's functional or medical status that requires updating the original plan, which includes an assessment of the change and a revised plan. This re-evaluation typically involves about 30 minutes of face-to-face time with the patient and/or family. |
| 97530 | Therapeutic activities, direct (one-on-one) patient care (use of dynamic activities to improve functional performance), each 15 minutes. |
| 97533 | Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes. |
| 97535 | Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal prep, safety procedures and instructions in use of assistive devices/adaptive equipment). Direct (one-on-one) patient contact, each 15 minutes. |
| 97537 | Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct (one-on-one) patient contact, each 15 minutes. |
| 97750 | Physical performance test or measurement (e.g., musculoskeletal, functional capacity) with written report, each 15 minutes. |
| 97760 | Orthotics management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes. |
| 97761 | Prosthetics training upper and/or lower extremities, initial prosthetic(s) encounter, each 15 minutes. |

Definitions

Place of Service Code

A two-digit code used on health care professional claims to indicate the setting in which a service was provided.

Place of Service - 22

A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

Edit Sources

- I. Current Procedural Terminology (CPT) and associated publications and services.
- II. Centers for Medicare & Medicaid Services (CMS), https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set_ <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files>

Attachments

N/A

Associated Policies

N/A

Policy History

| | |
|---------|--|
| 02/2026 | Reimbursement Policy Committee Approval |
| 01/2026 | Added coverage clarification of PT, OT and SP as an outpatient. |
| 11/2025 | Reimbursement Policy Committee Approval |
| 10/2025 | Annual review <ul style="list-style-type: none">• No revisions |
| 06/2025 | Minor updates to formatting and syntax |
| 04/2025 | Revised preamble |
| 06/2024 | Reimbursement Policy Committee Approval |
| 04/2024 | Revised preamble |
| 08/2023 | Policy implemented by AmeriHealth Caritas Delaware removed from Policy History section |
| 01/2023 | Template revised <ul style="list-style-type: none">• Revised preamble• Removal of Applicable Claim Types table• Coding section renamed to Reimbursement Guidelines• Added Associated Policies section |