CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3586	**Date: August 12, 2016**
	Change Request 9726

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 16, 2016. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: New Place of Service (POS) Code for Telehealth and Distant Site Payment Policy

I. SUMMARY OF CHANGES: This Change Request creates a new POS code for Telehealth.

EFFECTIVE DATE: January 1, 2017 - Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the code set in effect the date the transaction is initiated. It is not date of service.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/20.4.2 Site of Service Payment Differential
R	12/190.6 Payment Methodology for Physician/Practitioner at the Distant Site
R	12/190.6.1 Submission of Telehealth Claims for Distant Site Practitioners
R	12/190.7 A/B MAC (B) Editing of Telehealth Claims
R	26/10.5 Place of Service Codes (POS) and Definitions

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3586	Date: August 12, 2016	Change Request: 9726

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I. GENERAL INFORMATION

A. Background: As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards and their implementation guides adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set maintained by the Centers for Medicare and Medicaid Services (CMS). As a payer, Medicare must be able to recognize as valid any valid code from the POS code set that appears on the HIPAA standard claim transaction.

The POS code set provides setting information necessary to appropriately pay Medicare and Medicaid claims. At times, Medicaid has had a greater need for specificity than has Medicare, and many of the new codes developed over the past few years have been to meet Medicaid's needs. While Medicare does not always need this greater specificity in order to appropriately pay claims, it nevertheless adjudicates claims with the new codes to ease coordination of benefits and to give Medicaid and other payers the setting information they require.

This Change Request (CR) updates the current POS code set by adding new POS code 02 for "The location where health services and health related services are provided or received, through telecommunication technology." Also, this CR will implement the systems and local contractor level changes needed for Medicare to adjudicate claims with the new POS code.

B. Policy: As discussed in the CY 2017 Physician Fee Schedule (PFS) proposed rule (published July 15, 2016), CMS is creating new POS code 02 for use by the physician or practitioner furnishing telehealth services from a distant site as follows:

<u>POS 02: Telehealth</u>

Descriptor: The location where health services and health related services are provided or received, through telecommunication technology.

Unless prohibited by national policy to the contrary, Medicare not only recognizes valid POS codes from the POS code set but also adjudicates claims having these codes. Although the Medicare program does not always have the same need for setting specificity as other payers, including Medicaid, adjudicating the claims eases the coordination of benefits for Medicaid and other payers who may need the specificity afforded by the entire POS code set.

Claims for covered services rendered via Telehealth at the distant site, if payable by Medicare, shall be paid at the Medicare Physician Fee Schedule facility rate. The list of Medicare Telehealth services which can be

billed with POS 02 is found on the CMS web site at www.cms.gov/Medicare/Medicare-General-Information/Telehealth/

The POS code for Telehealth would not apply to originating site facilities billing a facility fee.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9726.1	Contractors shall be aware of and apply the changes in the manual instructions for Telehealth and the revised the place of service (POS) code set and coding instructions.	X	X		X					
9726.2	Effective for claims processed on or after January 1, 2017, contractors shall add POS 02 to the POS code set for "The location where health services and health related services are provided or received, through telecommunication technology." described in Pub. 100-04, chapter 26, section 10.5, applying business requirement numbers 3 through 5 (below) as appropriate.		X		X		X			COBA
9726.3	Contractors shall determine the policies applicable to POS code 02 within the constraints of applicable national Medicare laws, regulations, and other policies.		X		X					
9726.4	Contractors shall adjudicate claims containing POS code 02 in accordance with its effective date.		X		X					
9726.5	Contractors shall pay the facility rate for covered Medicare Physician Fee Schedule (MPFS) services performed by the distant site practitioner that are payable via Telehealth.		X				X			
9726.6	Contractors shall pay the Telehealth distant site facility fee based on the MPFS facility rate for CAH method II providers (TOB 85X) for dates of service on or after January 1, 2017.					X				
9726.7	Contractors shall only allow the services on the list of Medicare Teleheath to be billed with POS 02, and with modifiers GT and GQ. NOTE: Modifiers GT and GQ continue to be required when billing for Medicare Telehealth services. The list		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	of Medicare Telehealth services is published each year on the CMS web site at www.cms.gov/Medicare/Medicare-General-Information/Telehealth/									
9726.7.1	When Telehealth procedure codes billed with POS 02 are billed without the GT or GQ modifier, contractors shall reject the service with the following messages, and use group code CO: CARC = 4 (The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.) RARC = MA130 (Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.)		X							
9726.7.2	When Telehealth procedure codes billed with modifiers GT or GQ are billed without POS 02, contractors shall reject the service with the following messages, and use group code CO: CARC = 5 (The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.) RARC = M77 (Missing/incomplete/invalid/inappropriate place of service.)		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
9726.8	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jamie Hermansen, 410-786-2064 or jamie.hermansen@cms.hhs.gov (Contact for place of service questions) , Tracey Mackey, 410-786-5736 or tracey.mackey@cms.hhs.gov (Part A billing and claims processing contact) , Brian Reitz, 410-786-5001 or brian.reitz@cms.hhs.gov (contact for practitioner claims processing questions)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

20.4.2 - Site of Service Payment Differential
(Rev. 3586, Issued:08-12-16 , Effective: 01-01-17, Implementation: 01-03-17)

Under the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians' services when provided in facility and nonfacility settings. The CMS furnishes both rates in the MPFSDB update.

The rate, facility or nonfacility, that a physician service is paid under the MPFS is determined by the Place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, nonphysician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or nonfacility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred. For the professional component (PC) of diagnostic tests, the facility and nonfacility payment rates are the same – irrespective of the POS code on the claim. See chapter 13, section 150 of this manual for POS instructions for the PC and technical component of diagnostic tests.

The list of settings where a physician's services are paid at the facility rate include:

- *Telehealth (POS 02);*
- Outpatient Hospital-Off campus (POS code 19);
- Inpatient Hospital (POS code 21);
- Outpatient Hospital-On campus (POS code 22);
- Emergency Room-Hospital (POS code 23);
- Medicare-participating ambulatory surgical center (ASC) for a HCPCS code included on the ASC approved list of procedures (POS code 24);
- Medicare-participating ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24);
- Military Treatment Facility (POS Code 26);
- Skilled Nursing Facility (SNF) for a Part A resident (POS code 31);
- Hospice – for inpatient care (POS code 34);
- Ambulance – Land (POS code 41);
- Ambulance – Air or Water (POS code 42);
- Inpatient Psychiatric Facility (POS code 51);
- Psychiatric Facility -- Partial Hospitalization (POS code 52);

- Community Mental Health Center (POS code 53);
- Psychiatric Residential Treatment Center (POS code 56); and
- Comprehensive Inpatient Rehabilitation Facility (POS code 61).

Physicians' services are paid at nonfacility rates for procedures furnished in the following settings:

- Pharmacy (POS code 01);
- School (POS code 03);
- Homeless Shelter (POS code 04);
- Prison/Correctional Facility (POS code 09);
- Office (POS code 11);
- Home or Private Residence of Patient (POS code 12);
- Assisted Living Facility (POS code 13);
- Group Home (POS code 14);
- Mobile Unit (POS code 15);
- Temporary Lodging (POS code 16);
- Walk-in Retail Health Clinic (POS code 17);
- Urgent Care Facility (POS code 20);
- Birthing Center (POS code 25);
- Nursing Facility and SNFs to Part B residents (POS code 32);
- Custodial Care Facility (POS code 33);
- Independent Clinic (POS code 49);
- Federally Qualified Health Center (POS code 50);
- Intermediate Health Care Facility/Mentally Retarded (POS code 54);
- Residential Substance Abuse Treatment Facility (POS code 55);
- Non-Residential Substance Abuse Treatment Facility (POS code 57);
- Mass Immunization Center (POS code 60);
- Comprehensive Outpatient Rehabilitation Facility (POS code 62);
- End-Stage Renal Disease Treatment Facility (POS code 65);

- State or Local Health Clinic (POS code 71);
- Rural Health Clinic (POS code 72);
- Independent Laboratory (POS code 81);and
- Other Place of Service (POS code 99).

See chapter 26, section 10.5 of this manual for the complete listing of the Place of Service code set, including instructions and special considerations for the application of certain POS codes under Medicare.

Nonfacility rates are applicable to outpatient rehabilitative therapy procedures, including those relating to physical therapy, occupational therapy and speech-language pathology, regardless of whether they are furnished in facility or nonfacility settings. Nonfacility rates also apply to all comprehensive outpatient rehabilitative facility (CORF) services. In addition, payment is made at the nonfacility rate for physician services provided to CORF patients and appropriately billed using POS code 62 for CORF.

190.6 - Payment Methodology for Physician/Practitioner at the Distant Site

(Rev.3586, Issued:08-12-16, Effective: 01-01-17, Implementation: 01-03-17)

1. Distant Site Defined

The term "distant site" means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system.

2. Payment Amount (professional fee)

The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current fee schedule amount for the service provided *at the facility rate*. Payment for an office visit, consultation, individual psychotherapy or pharmacologic management via a telecommunications system should be made at the same *facility* amount as when these services are furnished without the use of a telecommunications system. For Medicare payment to occur, the service must be within a practitioner's scope of practice under State law. The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

3. Medicare Practitioners Who May Receive Payment at the Distant Site (i.e., at a site other than where beneficiary is)

As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under state law. When the physician or practitioner at the distant site is licensed under state law to provide a covered telehealth service (i.e., professional consultation, office and other outpatient visits, individual psychotherapy, and pharmacologic management) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

If the physician or practitioner at the distant site is located in a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH, the CAH bills its regular A/B/MAC (A) for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

4. Medicare Practitioners Who May Bill for Covered Telehealth Services are Listed Below (subject to State law)

Physician
Nurse practitioner
Physician assistant
Nurse-midwife
Clinical nurse specialist
Clinical psychologist*
Clinical social worker*
Registered dietitian or nutrition professional
Certified registered nurse anesthetist

*Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners

(Rev.3586, Issued:08-12-16, Effective: 01-01-17, Implementation: 01-03-17)

Claims for telehealth services are submitted to the contractors that process claims for the performing physician/practitioner's service area. Physicians/practitioners submit the appropriate HCPCS procedure code for covered professional telehealth services *with place of service code 02 (Telehealth)* along with the "GT" modifier ("via interactive audio and video telecommunications system"). By coding and billing the "GT" modifier with a covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. By coding and billing the "GT" modifier with a covered ESRD-related service telehealth code, the distant site physician/practitioner certifies that 1 visit per month was furnished face-to-face "hands on" to examine the vascular access site. Refer to section 190.3.4 of this chapter for the conditions of telehealth payment for ESRD-related services.

In situations where a CAH has elected payment Method II for CAH outpatients, and the practitioner has reassigned his/her benefits to the CAH, A/B/MACs (A) should make payment for telehealth services provided by the physician or practitioner at 80 percent of the MPFS *facility* amount for the distant site service. In all other cases, except for MNT services as discussed in Section 190.7- *A/B MAC (B)* Editing of Telehealth Claims, telehealth services provided by the physician or practitioner at the distant site are billed to the A/B/MAC (B).

Physicians and practitioners at the distant site bill their A/B/MAC (B) for covered telehealth services, for example, "99245 GT." Physicians' and practitioners' offices serving as a telehealth originating site bill their A/B/MAC (B) for the originating site facility fee.

190.7 - A/B MAC (B) Editing of Telehealth Claims

(Rev.3586, Issued: 08-12-16; Effective: 01-01-17; Implementation: 01-03-17)

Medicare telehealth services (as listed in section 190.3) are billed with either the "GT" or "GQ" modifier. The A/B MAC (B) shall approve covered telehealth services if the physician or practitioner is licensed under State law to provide the service. A/B MACs (B) must familiarize themselves with licensure provisions of States for which they process claims and disallow telehealth services furnished by physicians or practitioners who are not authorized to furnish the applicable telehealth service under State law. For example, if a nurse practitioner is not licensed to provide individual psychotherapy under State law, he or she would not be permitted to receive payment for individual psychotherapy under Medicare. The A/B MAC (B) shall install edits to ensure that only properly licensed physicians and practitioners are paid for covered telehealth services.

If an A/B MAC (B) receives claims for professional telehealth services coded with the "GQ" modifier (representing "via asynchronous telecommunications system"), it shall approve/pay for these services only if the physician or practitioner is affiliated with a Federal telemedicine demonstration conducted in Alaska or Hawaii. The A/B MAC (B) may require the physician or practitioner at the distant site to document his or her participation in a Federal telemedicine demonstration program conducted in Alaska or Hawaii prior to paying for telehealth services provided via asynchronous, store and forward technologies.

If an A/B MAC (B) denies telehealth services because the physician or practitioner may not bill for them, the A/B MAC (B) uses MSN message 21.18: "This item or service is not covered when performed or ordered by this practitioner." The A/B MAC (B) uses remittance advice message 52 when denying the claim based upon MSN message 21.18.

If a service is billed with one of the telehealth modifiers and the procedure code is not designated as a covered telehealth service, the A/B MAC (B) denies the service using MSN message 9.4: "This item or service was denied because information required to make payment was incorrect." The remittance advice message depends on what is incorrect, e.g., B18 if procedure code or modifier is incorrect, 125 for submission billing errors, 4-12 for difference inconsistencies. The A/B MAC (B) uses B18 as the explanation for the denial of the claim.

The only claims from institutional facilities that A/B MACs (A) shall pay for telehealth services at the distant site, except for MNT services, are for physician or practitioner services when the distant site is located in a CAH that has elected Method II, and the physician or practitioner has reassigned his/her benefits to the CAH. The CAH bills its regular A/B MAC (A) for the professional services provided at the distant site via a telecommunications system, in any of the revenue codes 096x, 097x or 098x. All requirements for billing distant site telehealth services apply.

Claims from hospitals or CAHs for MNT services are submitted to the hospital's or CAH's regular A/B MAC (A). Payment is based on the facility amount on the Medicare Physician Fee Schedule for the particular HCPCS codes.

Medicare Claims Processing Manual
Chapter 26 - Completing and Processing Form CMS-1500 Data Set

10.5 - Place of Service Codes (POS) and Definitions
(Rev.3586, Issued:08-12-16, Effective: 01-01-17, Implementation: 01-03-17)

- HIPAA
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) became effective October 16, 2003, for all covered entities. Medicare is a covered entity under HIPAA.
  - The final rule, "Health Insurance Reform: Standards for Electronic Transactions," published in the **Federal Register**, August 17, 2000, adopts the standards to be used under HIPAA and names the implementation guides to be used for these standards. The ASC X12N 837 professional is the standard to be used for transmitting health care claims electronically, and its implementation guide requires the use of POS codes from the National POS code set, currently maintained by CMS.
  - As a covered entity, Medicare must use the POS codes from the National POS code set for processing its electronically submitted claims. Medicare must also recognize as valid POS codes from the POS code set when these codes appear on such a claim.
  - Medicare must recognize and accept POS codes from the national POS code set in terms of HIPAA compliance. Note special considerations for Homeless Shelter (code 04), Indian Health Service (codes 05, 06), Tribal 638 (codes 07, 08), and 09 Prison/Correctional Facility settings, described below. Where there is no national policy for a given POS code, local contractors may work with their medical directors to develop local policy regarding the services payable in a given setting, and this could include creating a crosswalk to an existing setting if desired. However, local contractors must pay for the services at either the facility or the nonfacility rate as designated below. In addition, local contractors, when developing policy, must ensure that they continue to pay appropriate rates for services rendered in the new setting; if they choose to create a crosswalk from one setting to another, they must crosswalk a facility rate designated code to another facility rate designated code, and a nonfacility rate designated code to another nonfacility rate designated code. For previously issued POS codes for which a crosswalk was mandated, and for which no other national Medicare directive has been issued, local contractors may elect to continue to use the crosswalk or develop local policy regarding the services payable in the setting, including another crosswalk, if appropriate. If a local contractor develops local policy for these settings, but later receives specific national instructions for these codes, the local contractors shall defer to and comply with the newer instructions. (**Note**: While, effective January 1, 2003, codes 03 School, 04 Homeless Shelter, and 20 Urgent Care became part of the National POS code set and were to be crosswalked to 11 Office, this mandate to crosswalk has since been lifted, as indicated above).
  - National policy in the form of "Special Considerations" for Off Campus-Outpatient Hospital (POS 19), Inpatient Hospital (POS code 21), On Campus-Outpatient Hospital (POS code 22), Ambulatory Surgical Center (POS code 24) and Hospice (POS code 34) are included below.
- The National POS Code Set and Instructions for Using It

The following is the current national POS code set, with facility and nonfacility designations noted for Medicare payment for services on the Physician Fee Schedule. As a new POS code is established, the health care industry is permitted to use this code from the date that it is posted on the Medicare Place of Service Code Set Web page at http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html which is typically expected to be some months ahead of the final effective date for Medicare use.

The code set is annotated with the effective dates for this and all other codes added on and after January 1, 2003. Codes without effective dates annotated are long-standing and in effect on and before January 1, 2003.

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
01 Pharmacy (October 1, 2005) A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.	NF
02 Telehealth (January 1, 2017) *The location where health services and health related services are provided or received, through telecommunication technology.*	*F*
03 School (January 1, 2003) A facility whose primary purpose is education.	NF
04 Homeless Shelter (January 1, 2003) A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (See "Special Considerations" below.)	NF
05 Indian Health Service Free-standing Facility (January 1, 2003) A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (See "Special Considerations" below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
06 Indian Health Service Provider-based Facility (January 1, 2003) A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (See "Special Considerations" below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
07 Tribal 638 Free-Standing Facility (January 1, 2003) A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
require hospitalization. (See "Special Considerations" below.)	
08 Tribal 638 Provider-Based Facility (January 1, 2003) A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (See "Special Considerations" below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
09 Prison/Correctional Facility (July 1, 2006) A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (See "Special Considerations" below.)	NF
10 Unassigned	--
11 Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	NF
12 Home Location, other than a hospital or other facility, where the patient receives care in a private residence.	NF
13 Assisted Living Facility (October 1, 2003) Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.	NF
14 Group Home (Code effective, October 1, 2003; description revised, effective April 1, 2004) A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).	NF
15 Mobile Unit (January 1, 2003) A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. (See "Special Considerations" below.)	NF
16 Temporary Lodging (April 1, 2008)	NF

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.	
17 Walk-in Retail Health Clinic (No later than May 1, 2010) A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (See "Special Considerations" below.)	NF
18 Place of Employment/Worksite (No later than May 1, 2013) A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
19 Off Campus-Outpatient Hospital (January 1, 2016) A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (See "Special Considerations" below.)	F
20 Urgent Care Facility (January 1, 2003) Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	NF
21 Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	F
22 On Campus-Outpatient Hospital (description revised January 1, 2016) 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. (See "Special Considerations" below.)	F
23 Emergency Room-Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	F
24 Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and	F

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
diagnostic services are provided on an ambulatory basis.	
25 Birthing Center A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.	NF
26 Military Treatment Facility A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).	F
27-30 Unassigned	--
31 Skilled Nursing Facility A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.	F
32 Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	NF
33 Custodial Care Facility A facility which provides room, board and other personal assistance services, generally on a longterm basis, and which does not include a medical component.	NF
34 Hospice A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	F
35-40 Unassigned	--
41 Ambulance—Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
42 Ambulance—Air or Water An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
43-48/Unassigned	--
49 Independent Clinic (October 1, 2003) A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.	NF
50 Federally Qualified Health Center A facility located in a medically underserved area that provides Medicare	NF

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
beneficiaries preventive primary medical care under the general direction of a physician.	
51 Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	F
52 Psychiatric Facility-Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	F
53 Community Mental Health Center A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.	F
54 Intermediate Care Facility/Mentally Retarded A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.	NF
55 Residential Substance Abuse Treatment Facility A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	NF
56 Psychiatric Residential Treatment Center A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	F
57 Non-residential Substance Abuse Treatment Facility (October 1, 2003) A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	NF
58-59 Unassigned	--
60 Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media	NF

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	
61 Comprehensive Inpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	F
62 Comprehensive Outpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	NF
63-64 Unassigned	--
65 End-Stage Renal Disease Treatment Facility A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	NF
66-70 Unassigned	--
71 State or Local Public Health Clinic A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.	NF
72 Rural Health Clinic A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	NF
73-80 Unassigned	--
81 Independent Laboratory A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	NF
82-98 Unassigned	--
99 Other Place of Service Other place of service not identified above.	NF

The Medicare contractor can provide guidance regarding which code applies in cases where the appropriate POS code may be unclear.

- **Special Considerations for Homeless Shelter (Code 04)**

  Note that for the purposes of receiving durable medical equipment (DME), a homeless shelter is considered the beneficiary's home. Because DME is payable in the beneficiary's home, the crosswalk for Homeless Shelter (code 04) to Office (code 11) that was mandated effective January 1, 2003, may need to be adjusted or local policy developed so that HCPCS codes for DME are covered when other conditions are met and the beneficiary is in a homeless shelter. If desired, local

contractors are permitted to work with their medical directors to determine a new crosswalk such as from Homeless Shelter (code 04) to Home (code 12) or Custodial Care Facility (code 33) for DME provided in a homeless shelter setting. If a local contractor is currently paying claims correctly, however, it is not necessary to change the current crosswalk.

- **Special Considerations for Indian Health Service (Codes 05, 06) and Tribal 638 Settings (Codes 07, 08)**

  Medicare does not currently use the POS codes designated for these settings. Follow the instructions you have received regarding how to process claims for services rendered in IHS and Tribal 638 settings. If you receive claims with these codes, you must initially accept them in terms of HIPAA compliance. However, follow your "return as unprocessable" procedures after this initial compliance check. Follow your "return as unprocessable" procedures when you receive paper claims with these codes. (Note that while these codes became part of the National POS code set effective January 1, 2003, Medicare contractors received instructions regarding how to process claims with these codes effective October 1, 2003, so that Medicare could be HIPAA compliant by October 16, 2003).

- **Special Considerations for Mobile Unit Settings (Code 15)**

  When services are furnished in a mobile unit, they are often provided to serve an entity for which another POS code exists. For example, a mobile unit may be sent to a physician's office or a skilled nursing facility. If the mobile unit is serving an entity for which another POS code already exists, providers should use the POS code for that entity. However, if the mobile unit is not serving an entity which could be described by an existing POS code, the providers are to use the Mobile Unit POS code 15. Apply the nonfacility rate to payments for services designated as being furnished in POS code 15; apply the appropriate facility or nonfacility rate for the POS code designated when a code other than the mobile unit code is indicated.

  A physician or practitioner's office, even if mobile, qualifies to serve as a telehealth originating site. Assuming such an office also fulfills the requirement that it be located in either a rural health professional shortage area as defined under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) or in a county that is not included in a Metropolitan Statistical Area as defined in section 1886(d)(2)(D) of the Act, the originating physician's office should use POS code 11 (Office) in order to ensure appropriate payment for services on the list of Medicare Telehealth Services.

- **Special Considerations for Prison/Correctional Facility Settings (Code 09)**

  The addition of code 09 to the POS code set and Medicare claims processing reflects Medicare's compliance with HIPAA laws and regulations. Local contractors must continue to comply with CMS current policy that does not allow payment for Medicare services in a penal institution in most cases. The addition of a POS code for a prison/correctional facility setting does not supersede this policy. (See Pub. 100-04, Medicare Claims Processing, section 10.4, chapter 1.)

- **Special Considerations for Walk-In Retail Health Clinic (Code 17)** (Effective no later than May 1, 2010)

  It should be noted that, while some entities in the industry may elect to use POS code 17 to track the setting of immunizations, Medicare continues to require its billing rules for immunizations claims, which are found in chapter 18, section 10 of this manual. Contractors are to instruct providers and suppliers of immunizations to continue to follow these Medicare billing rules. However, Medicare contractors are to accept and adjudicate claims containing POS code 17, even if its presence on a claim is contrary to these billing instructions.

- **Special Considerations for Services Furnished to Registered Inpatients**

When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, 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. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF receiving inpatient skilled nursing care, POS 51, for a patient registered in a Psychiatric Inpatient Facility, and POS 61 for patients registered in a Comprehensive Inpatient Rehabilitation Facility.

- **Special Considerations for Outpatient Hospital Departments**

The place of service (POS) code for "Outpatient Hospital" has been expanded. The description of POS 22 has been revised from "Outpatient Hospital" to "On Campus-Outpatient Hospital" and POS 19 has been created for the "Off Campus-Outpatient Hospital" setting. Throughout this Internet Only Manual (IOM) you may find references to "Outpatient Hospital" that do not differentiate between the "On Campus" or "Off Campus" setting; however, any reference to POS 22 (formerly "Outpatient Hospital") found anywhere within the IOM is now defined as "On Campus-Outpatient Hospital." In addition, POS 19 will also apply in the majority of situations describing an outpatient hospital setting.

When a physician/practitioner furnishes services to an outpatient of a hospital, payment is made under the PFS at the facility rate. Physicians/practitioners who furnish services to a hospital outpatient, including in a hospital outpatient department (including in a provider-based department of that hospital) or under arrangement to a hospital shall, at a minimum, report the off campus-outpatient hospital POS code 19 or on campus-outpatient hospital POS code 22 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the outpatient hospital POS code 19 or 22 is a minimum requirement for purposes of triggering the facility payment amount under the PFS when services are provided to a registered outpatient. If the physician/practitioner is aware of the exact setting where the beneficiary is a registered hospital outpatient, the appropriate outpatient facility POS code may be reported consistent with the code list annotated in this section (instead of POS 19 or 22). For example, physicians/practitioners may use POS code 23 for services furnished to a patient registered in the emergency room, POS 24 for patients registered in an ambulatory surgical center, and POS 56 for patients registered in a psychiatric residential treatment center.

NOTE: Physicians/practitioners who perform services in a hospital outpatient department shall use, at a minimum, POS code 19 (Off Campus-Outpatient Hospital) or POS code 22 (On Campus-Outpatient Hospital). Code 19 or 22 (or other appropriate outpatient department POS code as described above) shall be used unless *t*he physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65. Physicians shall use POS code 11 (office) when services are performed in a *s*eparately maintained physician office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital. Use of POS code 11(office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

- **Special Consideration for Ambulatory Surgical Centers (Code 24)**

When a physician/practitioner furnishes services to a patient in a Medicare-participating ambulatory surgical center (ASC), the POS code 24 (ASC) shall be used.

NOTE: Physicians/practitioners who perform services in an ASC shall use POS code 24 (ASC). Physicians/practitioners are not to use POS code 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC, which meets all other requirements for operating as a physician office at the same physical location as the ASC – including meeting the "distinct entity" criteria defined in the ASC State Operations Manual that precludes the ASC and an adjacent physician office from being open at the same time -- and the physician service was actually performed in the office suite portion of the facility.

See Pub 100-07, Medicare State Operations Manual, Appendix L - Guidance for Surveyors: Ambulatory Surgical Centers for a complete set of applicable ASC definitions, basic requirements, and conditions of coverage. It is available at the following link: http://www.cms.gov/manuals/Downloads/som107ap_l_ambulatory.pdf

- **Special Considerations for Hospice (Code 34)**

  When a physician/practitioner furnishes services to a patient under the hospice benefit, use the following guidelines to identify the appropriate POS.

  When a beneficiary is in an "inpatient" respite or general "inpatient" care stay, the POS code 34 (hospice) shall be used. When a beneficiary who has elected coverage under the Hospice benefit is receiving inpatient hospice care in a hospital, SNF**,** or hospice inpatient facility, POS code 34 (Hospice) shall be used to designate the POS on the claim.

  For services provided to a hospice beneficiary in an outpatient setting, such as the physician/nonphysician practitioner's office (POS 11); the beneficiary's home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., off campus-outpatient hospital (POS 19) or on campus-outpatient hospital (POS 22)), the patient's physician or nonphysician practitioner or hospice independent attending physician or nurse practitioner, shall assign the POS code that represents that setting, as appropriate.

  There may be use of nursing homes as the hospice patient's "home," where the patient resides in the facility but is receiving a home level of care. In addition, hospices are also operating "houses" or hospice residential entities where hospice patients receive a home level of care. In these cases, physicians and nonphysician practitioners, including the patient's independent attending physician or nurse practitioner, shall use the appropriate POS code representing the particular setting, e.g., POS code 32 for nursing home, POS code 13 for an assisted living facility, or POS code 14 for group home.

- **Paper Claims**

  Adjudicate paper claims with codes from the National POS code set as you would for electronic claims.