CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2679	**Date: March 29, 2013**
	Change Request 7631

Transmittal 2613, dated December 14, 2012, is being rescinded and replaced by Transmittal 2679, to indicate that clarification on the place of service for pathology and laboratory services will be provided through another Change Request. All other information remains the same.

SUBJECT: Revised and Clarified Place of Service (POS) Coding Instructions

I. SUMMARY OF CHANGES: This CR revises and clarifies national policy for POS code assignment. Instructions are provided regarding the assignment of place of service (POS) for all services paid under the Medicare Physician Fee Schedule and for certain services provided by independent labs. In addition to establishing a national policy for the correct assignment of POS codes, instructions are provided for the interpretation or professional component (PC) and the technical component (TC) of diagnostic tests.

EFFECTIVE DATE: April 1, 2013
IMPLEMENTATION DATE: April 1, 2013

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/20.4.2/Site of Service Payment Differential
R	13/Table of Contents
N	13/150/Place of Service (POS) Instructions for the Professional Component (PC or Interpretation) and the Technical Component (TC) of Diagnostic Tests
R	26/10.4/Items 14-33 - Provider of Service or Supplier Information
R	26/10.5/Place of Service Codes (POS) and Definitions
R	26/10.6/Carrier Instructions for Place of Service (POS) Codes

III. FUNDING:

For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2679	Date: March 29, 2013	Change Request: 7631

Transmittal 2613, dated December 14, 2012, is being rescinded and replaced by Transmittal 2679, to indicate that clarification on the place of service for pathology and laboratory services will be provided through another Change Request. All other information remains the same.

SUBJECT: Revised and Clarified Place of Service (POS) Coding Instructions

Effective Date: April 1, 2013
Implementation Date: April 1, 2013

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 (PO**S**) code from the POS code set maintained by the Centers for Medicare and Medicaid Services (CMS). Under Medicare, the correct POS code assignment is also required on the paper claim Form CMS 1500 (or its electronic equivalent). While CMS currently maintains the National POS code set, it is used by all other public and private health insurers, including Medicaid. At the time a POS code is developed, CMS determines whether a Medicare Physician Fee Schedule (MPFS) facility or nonfacility payment rate is appropriate for that setting and Medicare contractors are required to make payment at the MPFS rate designated for each POS code. Under the MPFS, physicians and other suppliers are required to report the setting, by selecting the most appropriate POS code, in which medically necessary services are furnished to beneficiaries. While Medicare contractors cannot create new POS codes, they are instructed to develop local policies that develop or clarify POS setting definitions in situations where national POS policy is lacking or unclear. Contractors must also ensure that the appropriate MPFS payment rate, facility or nonfacility, is applied to each "new" setting described by local policy.

The importance of this national policy is underscored by consistent findings, in annual and/or biennial reports from CY 2002 through CY 2007, by the Office of the Inspector General (OIG) that physicians and other suppliers frequently incorrectly report the POS in which they furnish services. This improper billing is particularly problematic when physician and other suppliers furnish services in outpatient hospitals and in ambulatory surgical centers (ASCs). In a sample of paid services (for services possessing both nonfacility and facility practice expense relative value units (RVUs)), the OIG found a significant percent of the sampled physician/practitioner claims were incorrectly reported by physician/practitioners as occurring in the office POS when those services were furnished in outpatient hospitals or ASCs. As such, these claims were paid by the contractor at the nonfacility rate -- rather than the lower facility MPFS payment rate assigned to the POS codes for outpatient hospitals and ASCs.

The OIG has called on CMS to instruct its contractors to strengthen the education process and reemphasize to physicians [including nonphysician practitioners and other suppliers] and their billing agents the importance of correctly coding the POS. Consequently, this instruction adds special considerations provisions regarding use of POS codes 22 and 24, for outpatient hospital and ambulatory surgical center (ASC) to chapter 26.

A previous CMS instruction Transmittal 1873 (CR 6375) (now rescinded) regarding the assignment of POS codes instructed physicians to use the 2-digit POS code to describe where he/she was physically when rendering

the service; in this instance, the POS code corresponded to the service location. [Claim Form CMS 1500 Items 24B and 32, respectively, and the corresponding loops on the ANSI 12X N 837-P electronic format information]. The service location information is used by physicians/practitioners/suppliers to report the name, address and ZIP code of the service location where they furnished services (e.g., hospital, clinic, or office) and is used by contractors to determine the applicable "locality" and GPCI-adjusted payment for each service paid under the MPFS.

This instruction establishes that for all services – with two (2) exceptions -- paid under the MPFS that the POS code to be used by the physician and other supplier shall be assigned as the same setting in which the beneficiary received the face-to-face service. Because a face-to-face encounter with a physician/practitioner is required for nearly all services paid under the MPFS and anesthesia services, this rule will apply to the overwhelming majority of PFS services. In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the professional component (PC)/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician /practitioner shall be the setting in which the beneficiary received the technical component (TC) service. For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary's MRI from his/her office location – POS code 22 shall be used on the physician's claim for the PC to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

There are two (2) exceptions to this face-to-face provision/rule in which the physician always uses the POS code where the beneficiary is receiving care as a registered inpatient or an outpatient of a hospital, regardless of where the beneficiary encounters the face-to-face service. The correct POS code assignment shall be for that setting in which the beneficiary is receiving inpatient care or outpatient care from a hospital including the inpatient hospital (POS code 21) or the outpatient hospital (POS code 22) In other words, reporting the inpatient hospital POS code 21 or the outpatient hospital POS code 22, is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient or an outpatient of a hospital respectively. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient (or hospital outpatient), the appropriate inpatient POS code (or appropriate outpatient POS code) may be reported consistent with the code list annotated in Pub. 100-04, Medicare Claims Processing Manual, chapter 26, section 10.5. However, it is more important that the physician/practitioner report the POS consistent with the patient's general inpatient or outpatient hospital status than the precise inpatient/ outpatient POS code (in order to trigger the facility payment rate under the PFS). Pub. 100-04, Medicare Claims Processing Manual, chapter 26, already requires this for physician services (and for certain independent laboratory services) provided to beneficiaries in the inpatient hospital and this CR clarifies this exception and extends it to beneficiaries of the outpatient hospital, as well.

This CR adds clarifying or special considerations provisions to chapter 26 for POS code 15 for mobile unit, POS code 17 for walk-in retail health clinic, POS 21 for inpatient hospital, POS 22 for outpatient hospital, POS code 24 for ASC, and POS code 34 for hospice. This CR also adds a new section to chapter 13 regarding POS instructions for the PC or Interpretation and the TC of Diagnostic Tests paid under the MPFS. In addition, this CR amends the site of service payment differential section of chapter 12 by updating and clarifying the POS code lists for which the MPFS facility and nonfacility rates are paid.

This CR reminds contractors of their obligation to edit for consistency or compatibility between the place of service and site-specific procedure codes and to edit for validity of the POS coding. Contractors are required to provide education to physicians/practitioners/suppliers and their billing entities about the obligation to correctly assign POS codes for all settings, and especially for physician services provided in outpatient hospitals (POS 22) and ASCs (POS 24).

B. Policy: Contractors are informed about the correct POS for physician and supplier services including those for the professional and technical components of diagnostic tests.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7631.1	Contractors shall be aware of and apply the revised place of service (POS) coding instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 26, sections 10.4 through 10.6.	X			X						
7631.1.1	Contractors shall educate physicians/practitioners and other suppliers about the general rule for the correct POS code assignment – use the POS code that reflects the setting in which the beneficiary received the face-face encounter.	X			X						
7631.1.2	Contractors shall educate physicians/practitioners and other suppliers about the two (2) exceptions to the general rule of POS code assignment, including: where the beneficiary is a registered inpatient or an outpatient of a hospital irrespective of where the face-to-face encounter occurred per the instructions in chapter 26, sections 10.4, 10.5 and 10.6.	X			X						
7631.1.3	Per the instructions in Pub 100-04, chapter 26, section 10.5, contractors shall educate physicians/practitioners and other suppliers – when a physician/practitioner/supplier furnishes services to an outpatient of a hospital, the outpatient hospital POS code 22 shall be used, irrespective of where the face-to-face encounter occurs. (As discussed under "special considerations" in chapter 26, section 10.5.)	X			X						
7631.1.4	Contractors shall educate physicians/practitioners and other suppliers – when a physician/practitioner/supplier furnishes services to a patient in a Medicare-participating ASC, the ASC POS 24 code shall be used.	X			X						
7631.1.5	Contractors shall educate physicians/practitioners and other suppliers – when a physician/practitioner/supplier furnishes services to an inpatient of a hospice, the hospice POS 34 code shall be used.	X			X						
7631.1.6	Contractors shall educate physicians/practitioners and other suppliers – when a physician/practitioner/supplier furnishes services to a registered inpatient, the inpatient hospital POS code 21 shall be used, irrespective of where the face-to-face encounter occurs. (As discussed under "special considerations" in chapter 26, section 10.5.)	X			X						

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7631.1.7	Contractors shall educate independent laboratory providers about the correct use of POS codes for laboratory samples drawn on patients who are registered inpatients or hospital outpatients. In these instances, the respective POS code for the inpatient hospital (POS code 21) or outpatient hospital (POS code 22) code is used, irrespective of where the face-to-face encounter occurs. (As discussed under "special considerations" in chapter 26, section 10.5.)	X			X						
7631.1.8	Contractors shall educate physicians and practitioners about the clarifying POS coding policy related to telehealth services, per the special considerations provision for mobile unit (POS code 15).	X			X						
7631.2	Contractors shall be aware of and apply the revised POS coding instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 20.4.2.	X			X						
7631.3	Contractors shall be aware of and apply the new POS coding instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 13, section 150.	X			X						
7631.3.1	Contractors shall educate physicians/practitioners and other suppliers about the correct use of POS codes for diagnostic services that are split into a technical component (TC) and a professional component (PC): the physician/practitioner shall use the same POS code that represents where the TC was provided (the beneficiary received the face-to-face encounter) for reporting the PC -- except in those cases where the beneficiary is a registered inpatient or an outpatient of a hospital. In these instances, the POS code for the inpatient hospital (POS code 21) or outpatient hospital (POS code 22) is used, irrespective of where the face-to-face encounter occurs. (As discussed under "special considerations" in chapter 26, section 10.5.)	X			X						
7631.3.2	Contractors generally shall not make payment for health care or supplies provided outside the United States. Exceptions to the outside the United States exclusion are cited in Pub. 100-04, chapter 26, section 10.6.1. Also see Pub. 100-02, Medicare Benefit Policy Manual, chapter 16, section 60 for a clarification of the subcontracting of services to another provider or supplier located outside the United States.	X			X						

Number	Requirement	Responsibility is indicated by an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7631.3.3	Contractors shall educate physicians/practitioners and other suppliers that there is no POS code for an interpretation that is provided under arrangement to a hospital for global services in which the test and interpretation are not separately billable (global service).	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
7631.4	A provider education article related to this instruction will be available at http:/www.cms.hhs.gov/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 site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement the MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s):
For payment policy questions please contact Craig Dobyski at (410) 786-4584 or Craig.Dobyski@cms.hhs.gov

Post-Implementation Contact(s):
Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No Additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

Chapter 12 - Physicians/Nonphysician Practitioners

20.4.2 - Site of Service Payment Differential

(Rev. 2679, Issued: 03-29-13, Effective: 04-01-13, Implementation: 04-01-13)

Under the *Medicare P*hysician *F*ee 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 code 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:

- Inpatient Hospital (POS code 21);
- *Outpatient Hospital (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);
- *S*killed *N*ursing *F*acilit*y* (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);*

- *I*npatient *P*sychiatric *F*acilit*y* (POS code 51);
- *Psychiatric Facility -- Partial Hospitalization (POS code 52);*
- *C*ommunity *M*ental *H*ealth *C*enter (POS code 53);
- *Psychiatric Residential Treatment Center (POS code 56); and*
- *C*omprehensive *I*npatient *R*ehabilitation *F*acilit*y* (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);*
- *H*ome *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.*

Chapter 13 - Radiology Services and Other Diagnostic Procedures

Table of Contents
(Rev.2679, 03-29-13)

150 - Place of Service (POS) Instructions for the Professional Component (PC or Interpretation) and the Technical Component (TC) of Diagnostic Tests

(Rev. 2679, Issued: 03-29-13, Effective: 04-01-13, Implementation: 04-01-13)

Many of the diagnostic services, including radiology services, provided by physicians/practitioners contain both a technical component (TC) and a professional component (PC). Often, the PC and TC of diagnostic services are furnished in different settings. As a general policy, the POS code assigned by the physician/practitioner for the PC of a diagnostic service shall be the setting in which the beneficiary received the TC service.

A. Interpretation Provided Telephonically by Wireless Remote

Teleradiology services (radiology services that do not require a face-to-face encounter with the patient furnished through the use of a telecommunications system) are discussed in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 30. The interpretation of an x-ray, electrocardiogram, electroencephalogram and tissue samples are listed as examples of these services.

In cases where the face-to-face requirement is obviated such as those when a physician/practitioner provides the PC/interpretation of a diagnostic test, from a distant site, the POS code assigned by the physician /practitioner shall be the setting in which the beneficiary received the TC service. The POS code for a teleradiology interpretation is generally the place where the beneficiary received the TC, or face-to-face encounter. The POS code representing the setting where the beneficiary received the TC is entered in item 24B on the paper claim Form CMS 1500 (or its electronic equivalent). In cases where it is unclear which POS code applies, the Medicare contractor can provide guidance.

For example: A beneficiary receives an MRI at an outpatient hospital near his/her home. The outpatient hospital submits a claim that would correspond to the TC portion of the MRI. The physician furnishes the PC portion of the beneficiary's MRI from his/her office location – POS code 22(Outpatient Hospital) shall be used on the physician's claim to indicate that the beneficiary received the face-to-face portion of the MRI, the TC, at the outpatient hospital.

B. Interpretation Provided Outside of the United States

Generally, Medicare will not pay for health care or supplies that are performed outside the United States (U.S.). The term "outside the U.S." means anywhere other than the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. See Pub. 100-02, chapter 16, section 60, for exceptions to the "outside the U.S." exclusions.

C. Interpretation Provided Under Arrangement --To A Hospital

Separate TC and PC

If a diagnostic test which has a separate TC and PC is provided under arrangement to a hospital, the physician who reads the test can bill and be paid for the professional component. Both the technical and professional components of the test are also subject to the physician self-referral prohibition.

The appropriate POS code for the interpretation (or PC) is the setting where the beneficiary received the TC service. If the interpretation is performed in the physician's office and the patient received the TC service in the provider-based outpatient hospital setting, the physician assigns POS code 22, for outpatient hospital, on the claim for the interpretation or PC.

Global Service

When a physician performs a diagnostic test under arrangement to a hospital and the test and the interpretation are not separately billable, the interpretation cannot be billed by the physician. In this scenario, the hospital is the only entity that can bill for the diagnostic test which encompasses the interpretation. There is no POS code for the interpretation since a physician claim is not generated.

D. Global Billing

Billing globally for services that are split into PC and TC components is only possible when the TC and the physician who provides the PC of the diagnostic service are furnished by the same physician or supplier entity and the PC and TC components are furnished within the same Medicare physician fee schedule payment locality. Merely applying the same POS code to the PC as that of the TC (as described in "A" above) does not permit global billing for any diagnostic procedure.

E. Determination of Payment Locality

Under the Medicare physician fee schedule (MPFS), payment amounts are based on the relative resources required to provide services and vary among payment localities as resource costs vary geographically as measured by the geographic practice cost indices (GPCIs). The payment locality is determined based on the location where a specific service code was furnished. For purposes of determining the appropriate payment locality, CMS requires that the address, including the ZIP code for each service code be included on the claim form in order to determine the appropriate payment locality. The location in which the service code was furnished is entered in Item 32 on the paper claim Form CMS 1500 (or its electronic equivalent).

Global Service Code

If the global diagnostic service code is billed, the biller (either the entity that took the test, physician who interpreted the test, or separate billing agent) must report the address and ZIP code of where the test was furnished on the bill for the global diagnostic service code. In other words, when the global diagnostic service code is billed, for example, chest x-ray as described by HCPCS code 71010 (no modifier TC and no modifier -26), the locality is determined by the ZIP code applicable to the testing facility, i.e. where the TC of the chest x-ray was furnished. The testing facility (or its billing agent) enters the address and ZIP code of the setting/location where the test took place. This practice location is entered in Item 32 on the paper claim Form CMS 1500 (or its electronic equivalent). As explained in D above, in order to bill for a global diagnostic service code, the same physician or supplier entity must furnish both the TC and the PC of the diagnostic service and the TC and PC must be furnished within the same MPFS payment locality.

Separate Billing of Professional Interpretation

If the same physician or other supplier entity does not furnish both the TC and PC of the diagnostic service, or if the same physician or other supplier entity furnishes both the TC and PC but the professional interpretation was furnished in a different payment locality from where the TC was furnished, the professional interpretation of a diagnostic test must be separately billed with modifier -26 by the interpreting physician.

When the physician's interpretation of a diagnostic test is billed separately from the technical component, as identified by modifier -26, the interpreting physician (or his or her billing agent) must report the address and ZIP code of the interpreting physician's location on the claim form. If the professional interpretation was furnished at an unusual and infrequent location for example, a hotel, the locality of the professional interpretation is determined based on the Medicare enrolled location where the interpreting physician most commonly practices. The address and ZIP code of this practice location is entered in Item 32 on the paper claim Form CMS 1500 (or its electronic equivalent).

Chapter 26 - Completing and Processing Form CMS-1500 Data Set

10.4 - Items 14-33 - Provider of Service or Supplier Information

(Rev. 2679, Issued: 03-29-13, Effective: 04-01-13, Implementation: 04-01-13)

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 15 - Leave blank. Not required by Medicare.

Item 16 - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;

- Consultative services;

- Durable medical equipment;

- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);

- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;

- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

- Effective for claims with dates of service on or after October 1, 2012, all claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner, require that the name and NPI of the certifying physician or nonphysician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b.

Item 17a – Leave blank.

Item 17b Form CMS-1500 – Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Item 18 - Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the NPI of his/her attending physician when a physician providing routine foot care submits claims.

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for

course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter demonstration ID number “56” for all national Laboratory Affordable Care Act Section 113 Demonstration Claims.

Enter the NPI of the physician who is performing the technical or professional component of a diagnostic test that is subject to the anti-markup payment limitation. (See Pub. 100-04, chapter 1, section 30.2.9 for additional information.)

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Individuals and entities who bill carriers or A/B MACs for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

Item 20 - Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation. Enter the acquisition price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no anti-markup tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple anti-markup tests, each test shall be submitted on a separate claim Form CMS-1500. Multiple anti-markup tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to the anti-markup payment limitation.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the NPI of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

For ambulance claims, enter the ZIP code of the loaded ambulance trip's point-of-pickup.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate Form CMS-1500.

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g., UN2 or F2999999).

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 day and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the *setting*, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a *patient who is a registered inpatient or an outpatient of a hospital, use the inpatient hospital POS code 21 or outpatient hospital POS code 22, respectively as discussed in section 10.5 of this chapter.*

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS

code modifiers with the HCPCS code. The Form CMS-1500 has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Item 24F- Enter the charge for each listed service.

Item 24G - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

Beginning with dates of service on and after January 1, 2011, for ambulance mileage, enter the number of loaded miles traveled rounded up to the nearest tenth of a mile up to 100 miles. For mileage totaling 100 miles and greater, enter the number of covered miles rounded up to the nearest whole number miles. If the total mileage is less than 1 whole mile, enter a “0” before the decimal (e.g. 0.9). See Pub. 100-04, chapter 15, §20.2 for more information on loaded mileage and §30.1.2 for more information on reporting fractional mileage.

NOTE: This field should contain an appropriate numerical value. The B/MAC should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable, except on claims for ambulance mileage. For ambulance mileage claims, contractors shall automatically default “0.1” unit when total mileage units are missing in this field.

Item 24H - Leave blank. Not required by Medicare.

Item 24I - Enter the ID qualifier 1C in the shaded portion.

Item 24J - Enter the rendering provider’s NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

Item 26 - Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;

- Physician services to individuals dually entitled to Medicare and Medicaid;

- Participating physician/supplier services;

- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;

- Ambulatory surgical center services for covered ASC procedures;

- Home dialysis supplies and equipment paid under Method II;

- Ambulance services;

- Drugs and biologicals; and

- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 – For services payable under the physician fee schedule and anesthesia services, **e**nter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-

1500, only one name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted. Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for anti-markup tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. (See Pub. 100-04, chapter 1, §10.1.1.2 for more information on payment jurisdiction for claims subject to the anti-markup limitation.)

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DME MAC only). This field is required. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a - If required by Medicare claims processing policy, enter the NPI of the service facility.

Item 32b - Effective May 23, 2008, Item 32b is not to be reported.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

Item 33b - Effective May 23, 2008, Item 33b is not to be reported.

10.5 - Place of Service Codes (POS) and Definitions

(Rev. 2679, Issued: 03-29-13, Effective: 04-01-13, Implementation: 04-01-13)

- 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 Inpatient Hospital (POS code 21), Outpatient Hospital (POS code 22), Ambulatory Surgical Center (POS code 24) and Hospice (POS code 34) are included below, effective April 1, 2012. The national policy instructions for the Walk-In Retail Health Clinic (POS code 17) that were previously addressed in this section are located in a special considerations provision 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, t*he health care industry is permitted to use this code from the date *that* it is posted on the Medicare POS code set Web page at http://www.cms.gov/place-of-service-codes/, 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 Unassigned	--
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 instructions below.)	NF
05 Indian Health Service Free-standing Facility (January 1, 2003)	Not applicable for adjudication

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
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 instructions below.)	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 instructions 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 require hospitalization. (See instructions below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
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 instructions 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 instructions 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	NF

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
or injury on an ambulatory basis.	
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.	NF
16 Temporary Lodging (April 1, 2008) 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.	NF
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.	*Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA*
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*	*Not applicable for adjudication of Medicare claims; systems must recognize*

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
or rehabilitative services to the individual.	*for HIPAA*
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 Outpatient Hospital A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	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 diagnostic services are provided on an ambulatory basis.	F
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
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

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
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 beneficiaries preventive primary medical care under the general direction of a physician.	NF

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
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	F

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
and learning environment.	
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 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.	NF
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	NF

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.	
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***

  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 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 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 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 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 22 (Outpatient Hospital). *Code 22 (or other appropriate outpatient department POS code as described above) shall be used unless the 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 separately 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., 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.

10.6 - Carrier Instructions for Place of Service (POS) Codes

(Rev. 2679, Issued: 03-29-13, Effective: 04-01-13, Implementation: 04-01-13)

For purposes of payment under the Medicare Physician Fee Schedule (MPFS), the POS code is generally used to reflect the actual setting where the beneficiary receives the face-to-face service. For example, if the physician's face-to-face encounter with a patient occurs in the office, the correct POS code on the claim, in general, reflects the 2-digit POS code 11 for office. In these instances, the 2-digit POS code (Item 24B on the claim Form CMS-1500) will match the address and ZIP entered in the service location (Item 32 on the 1500 Form) – the physical/geographical location of the physician. However, there are two exceptions to this general rule – these are for a service rendered to a patient who is a registered inpatient or an outpatient of a hospital. In these cases, the correct POS code -- regardless of where the face-to-face service occurs -- is that of the appropriate inpatient POS code (at a minimum POS code 21) or that of the appropriate outpatient hospital POS code (at a minimum POS code 22) as discussed in section 10.5 of this chapter. So, if in the above example, the patient seen in the physician's office is actually an inpatient of the hospital, POS code 21, for inpatient hospital, is correct. In this example, the POS code reflects a different setting than the address and ZIP code of the practice location (the physician's office).

For MPFS payment purposes the determinant of payment is the locality where the physician or supplier furnished the service. Medicare has both facility and non-facility designations for services paid under the physician fee schedule. In accordance with Chapter 1, Section 10.1.1 (Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services) of this manual, the jurisdiction for processing a request for payment for services paid under the MPFS is governed by the payment locality where the physician or supplier furnished the service and will be based on the ZIP code. CMS requires that the address and ZIP code of the physician's practice location be placed on the claim form in order to determine the

appropriate locality -- item 32 on the paper claim Form CMS 1500 or in the corresponding loop on its electronic equivalent.

For specific POS instructions and determination of the applicable payment locality for the PC (professional interpretation) and the TC of diagnostic tests see chapter 13, section 150 of this manual. For general policy on POS code assignment, see chapter 12, section 20.4.2 of this manual regarding the site of service payment differential under MPFS.

If the physician bills for lab services performed in his/her office, the *POS* code for "Office" is shown. If the physician bills for a lab test furnished by another physician, who maintains a lab in his/her office, the code for "Other" is shown. If the physician bills for a lab service furnished by an independent lab, the code for "Independent Laboratory" is used. Items 21 and 22 on the Form CMS-1500 must be completed for all laboratory work performed outside a physician's office. If an independent lab bills, the place where the sample was taken is shown. An independent laboratory taking a sample in its laboratory shows "81" as place of service. If an independent laboratory bills for a test on a sample drawn on a*n inpatient or outpatient of a hospital,* it uses the code for *the inpatient (POS code 21) or outpatient hospital (POS code 22), respectively*.

For hospital visits by physicians, presume, in the absence of evidence to the contrary, that visits billed for were made. However, review a sample of physician's records when there are questionable patterns of utilization. Confirm these visits where the medical facts do not support the frequency of the physician's visits or in cases of beneficiary complaints.

If questioning whether the visit had been made, ascertain whether the physician's own entry is in the patient's record at the provider. Accept an entry where the nurses' notes indicate that the physician saw the patient on a given day. A statement by the beneficiary is also acceptable documentation if it was made close to the alleged date of the visit. Entries in the physician's records represent possible secondary evidence. However, these are of less value since they are self-serving statements. Exercise judgment regarding their authenticity. The policy requiring daily physician visits is not conclusive if, in the individual case, the facts did not support a finding that daily visits were made.

If a claim lacks a valid place of service (POS) code in item 24b, or contains an invalid POS in item 24b, return the claim as unprocessable to the provider or supplier, using RA remark code M77. Effective for claims received on or after April 1, 2004, *only one POS may be submitted* on the Form CMS-1500 for services paid under the MPFS and anesthesia services. If the place of service is missing and the carrier cannot infer the place of service from the procedure code billed (e.g., a procedure code for which the definition is not site specific or which can be performed in more than one setting), then return assigned services as unprocessable and develop for the place of service on nonassigned claims.

If place of service is inconsistent with procedure code billed, then edit for consistency or compatibility between the place of service and site-specific procedure codes. If the place of service is valid but inconsistent or incompatible with the procedure billed (e.g., the

place of service is inpatient hospital and the procedure code billed is office visit), then return assigned services as unprocessable and develop nonassigned services since the carrier typically will not know whether the procedure code or the place of service is incorrect in such instances. If place of service is invalid, then edit for the validity of the place of service coding. If the place of service code is not valid (e.g., the number designation has not been assigned or defined by CMS), then return assigned services as unprocessable and develop for a valid place of service on nonassigned line items.