CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2744	**Date: July 24, 2013**
	Change Request 8392

Transmittal 2738, dated July 12, 2013, is being rescinded and replaced by Transmittal 2744 to remove DME MAC responsibility from business requirement 8392.1. All other information remains the same.

SUBJECT: Type of Service (TOS) Corrections 2013

I. SUMMARY OF CHANGES: This transmittal is being issued to correct several type of service (TOS) inconsistencies that were not in the Annual 2013 TOS update (Change Request 8082, Transmittal 2598). These changes are in the Attachment A. The Recurring Update Notification applies to chapter 26, section 10.7.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: October 7, 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	26/10.7/Type of Service

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with 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 obliged 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:

Recurring Update Notification

Manual Instruction

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

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 2744	Date: July 24, 2013	Change Request: 8392

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SUBJECT: Type of Service (TOS) Corrections 2013

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: October 7, 2013

I. GENERAL INFORMATION

A. Background: Type of Service (TOS) is an indicator that the MAC/carrier places on the Part B claim record. The indicator is mainly used for data purposes. However, in some instances it affects payment. All Healthcare Common Procedure Coding System (HCPCS) codes have a corresponding TOS indicator.

B. Policy: This instruction corrects several type of service (TOS) inconsistencies that were not included in the 2013 annual TOS update in CR 8082, Transmittal 2598.

The Common Working File currently accepts the TOS indicators outlined in this instruction. Therefore, claims will not reject when MAC/carriers begin applying the specified TOS indicators listed in this instruction.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8392.1	Contractors shall manually change the TOS indicators for the HCPCS codes listed in Attachment A.		X				X					X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	None								

IV. SUPPORTING INFORMATION

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

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: CR 8082

V. CONTACTS

Pre-Implementation Contact(s): Joscelyn Lissone, 410-786-5116 or joscelyn.lissone@cms.hhs.gov, April Billingsley, 410-786-0140 or april.billingsley@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; Contractors activities are to be carried out with 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 do 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.

Attachment

ATTACHMENT A

TOS CORRECTIONS

HCPCS Code	Type of Service (TOS)
90685	V
90686	V
90687	V
90688	V
90739	V
92920	2
92921	2
92924	2
92925	2
92928	2
92929	2
92933	2
92934	2
92937	2
92938	2
92941	2
92943	2
92944	2
95782	5
95783	5
95907	1
95908	1
95909	1
95910	1
95911	1
95912	1
95913	1
95924	1
95940	1
95941	1
95943	1

10.7 - Type of Service (TOS)

(Rev. 2744, Issued: 07-24-13, Effective: 01-01-13, Implementation: 10-07-13)

Medicare *administrative contractors* must assign the proper TOS *using the 2013 annual HCPCS update from the CMS mainframe. Changes to this list are issued annually via a Recurring Update Notification*. Some procedures may have more than one applicable TOS. For claims received on or after April 3, 1995, CWF *produced* alerts on codes with incorrect TOS designations. Effective July 3, 1995, CWF *began* rejecting codes with incorrect TOS designations.

The only exceptions to this *annual update* are:

- Surgical services billed for dates of service through December 31, 2007, containing the ASC facility service modifier SG must be reported as TOS F. Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare services. ASC providers should discontinue applying the SG modifier on ASC facility claims. The indicator 'F' does not appear in the TOS table because its use depends upon claims submitted with POS 24 (ASC Facility) from an ASC (specialty 49). This became effective for dates of service January 1, 2008 and after.

- Surgical services billed with an assistant-at-surgery modifier (80-82, AS,) must be reported with TOS 8. The 8 indicator does not appear on the TOS table because its use is dependent upon the use of the appropriate modifier. (See Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, "Physician/Nonphysician Practitioner," for instructions on when assistant-at-surgery is allowable.)

- Psychiatric treatment services that are subject to the outpatient mental health treatment limitation should be reported with TOS T.

- TOS H appears in the list of descriptors. However, it does not appear in the table. In CWF, "H" is used only as an indicator for hospice. The *contractor* should not submit TOS H to CWF at this time.

- For outpatient services, when a transfusion medicine code appears on a claim that also contains a blood product, the service is paid under reasonable charge at 80%, coinsurance and deductible apply. When transfusion medicine codes are paid under the clinical laboratory fee schedule pay at 100%, coinsurance and deductible do not apply.

NOTE: For injection codes with more than one possible TOS designation, use the following guidelines when assigning the TOS:

When the choice is L or 1,

- Use TOS L when the drug is used related to ESRD; or

- Use TOS 1 when the drug is not related to ESRD and is administered in the office.

When the choice is G or 1:

- Use TOS G when the drug is an immunosuppressive drug; or

- Use TOS 1 when the drug is used for other than immunosuppression.

When the choice is P or 1,

- Use TOS P if the drug is administered through durable medical equipment (DME); or
- Use TOS 1 if the drug is administered in the office.

The place of service or diagnosis may be considered when determining the appropriate TOS. The descriptors for each of the TOS codes listed in the *annual HCPCS update* are:

Type of Service Indicators

0	Whole Blood
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Laboratory
6	Therapeutic Radiology
7	Anesthesia
8	Assistant at Surgery
9	Other Medical Items or Services
A	Used DME
B	High Risk Screening Mammography
C	Low Risk Screening Mammography
D	Ambulance
E	Enteral/Parenteral Nutrients/Supplies
F	Ambulatory Surgical Center (Facility Usage for Surgical Services)
G	Immunosuppressive Drugs
H	Hospice
J	Diabetic Shoes
K	Hearing Items and Services
L	ESRD Supplies
M	Monthly Capitation Payment for Dialysis
N	Kidney Donor
P	Lump Sum Purchase of DME, Prosthetics, Orthotics
Q	Vision Items or Services
R	Rental of DME
S	Surgical Dressings or Other Medical Supplies
T	Outpatient Mental Health Treatment Limitation
U	Occupational Therapy
V	Pneumococcal/Flu Vaccine
W	Physical Therapy