CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1806	**Date: August 28, 2009**
	Change Request 6629

SUBJECT: October 2009 Update to the Ambulatory Surgical Center (ASC) Payment System; Summary of Payment Policy Changes

I. SUMMARY OF CHANGES: This Recurring Update Notification updates Pub. 100-04, chapter 26, section 10.5 to remove the notation in the payment rate section of the table for item 24- ASC. This instruction also provides billing instructions for payment policies implemented in the October 2009 ASC payment system update.

New / Revised Material
Effective Date: October 1, 2009
Implementation Date: October 5, 2009

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	26/10.5/Place of Service Codes (POS) and Definitions

III. FUNDING:
SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

Manual Instruction

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 1806	Date: August 28, 2009	Change Request: 6629

SUBJECT: October 2009 Update to the Ambulatory Surgical Center (ASC) Payment System; Summary of Payment Policy Changes

Effective Date: October 1, 2009

Implementation Date: October 5, 2009

I. GENERAL INFORMATION

A. Background: This Recurring Update Notification updates Pub. 100-04, chapter 26, section 10.5 and also describes changes to, and billing instructions for, payment policies implemented in the October 2009 ASC payment system update. Final policy under the revised ASC payment system, as set forth in Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs), beginning in CY 2008, (72 FR 42470), requires that ASC payment rates for covered separately payable drugs and biologicals be consistent with the payment rates under the Medicare hospital outpatient prospective payment system (OPPS). Those rates are updated quarterly. Therefore, beginning with Transmittal 1488, (CR 5994) issued April 9, 2008, CMS has issued quarterly updates to ASC payment rates for separately paid drugs and biologicals. CMS also updates the lists of covered surgical procedures and covered ancillary services to include newly created HCPCS codes as appropriate. This instruction provides information on the new HCPCS code for one separately payable drug that will be added to the ASC list of covered ancillary items effective October 1, 2009.

The policies related to the CMS updates to the ASC payment system are included in the 2008 ASC payment system instructions: Transmittal 1325 (CR5680), issued August 29, 2007, Transmittal 1415 (CR5885), issued January 18, 2008, and Transmittal 1616 (CR6184), issued October 17, 2008.

In this CR, CMS is issuing instructions to contractors to modify their systems to accept the October 2009 Ambulatory Surgical Center Fee Schedule (ASCFS), the October 2009 Ambulatory Surgical Center Payment Indicator (ASC PI) file, and the updated April 2008, July 2008, October 2008, and July 2009 ASC DRUG files and to ensure that the updated files properly interface with all other ASC module programming. The October 2009 ASC PI file and the April 2008, July 2008, October 2008, and July 2009 ASC DRUG files are full replacement files and the October 2009 ASCFS file contains only changes. The drug files include payment rates for all separately payable drugs and biologicals for the designated quarter, the ASCFS includes payment rates for new separately payable items and services, and the ASC PI file includes the payment indicators for payable and non-payable ASC services.

HCPCS code Q2024 is included in the October 2009 quarterly updates transmittals for the OPPS and ASC payment system. However, this code is not on the 2009 HCPCS file. Medicare contractors shall manually add this code to their systems.

In accordance with the instructions in Pub. 100-04, chapter 23, section 20.3, contractors shall incorporate into their systems, as appropriate, the HCPCS changes. Payment, status, and/or comment indicators for this code will be listed in the October 2009 updates of the OPPS and ASC addenda on the CMS Web site.

B. Policy:

1. Billing for Drugs and Biologicals

ASCs are strongly encouraged to report charges for all separately payable drugs and biologicals, using the correct HCPCS codes for the items used. ASCs billing for these products must make certain that the reported units of service for the reported HCPCS codes are consistent with the quantity of the drug or biological that was used in the care of the patient. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.

The CMS reminds ASCs that under the ASC payment system if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified drug or biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed.

Updated drug payment rates effective October 1, 2009, are included in the October 1, 2009 updated ASC Addendum BB that will be posted on the CMS Web site at the end of September.

Instructions for downloading the ASC DRUG file updates are included in the business requirements section below.

a. New HCPCS Drug Code That Is Separately Payable Under the ASC Payment System as of October 1, 2009

A new HCPCS code has been created for dates of service on or after October 1, 2009. The new HCPCS code, its descriptor, and payment indicator (PI) is identified in Table 1 below. This new separately payable drug code and its payment rate is included in the October 2009 ASC DRUG file.

Table 1- New Drugs and Biologicals Separately Payable under the ASC Payment System Effective October 1, 2009.

HCPCS	Long Descriptor	P I
Q2024	Injection, Bevacizumab, 0.25 mg	K2

b. ASC Payment Rate for Certain Newly Payable HCPCS Code Effective October 1, 2009

For dates of service beginning October 1, 2009, HCPCS code Q4115 (Skin substitute, alloskin, per square centimeter) is eligible for separate payment under the ASC payment system when it is provided integral to a covered surgical procedure. HCPCS code Q4115, the long descriptor, and the updated PI are displayed in Table 2 below. This separately payable drug code is included in the October ASC DRUG file.

Table 2- ASC Payment Rate for Certain Newly Payable HCPCS Code Effective October 1, 2009

HCPCS	Long Descriptor	PI
Q4115	Skin substitute, alloskin, per square centimeter	K2

c. Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

The payment rates for several HCPCS codes were incorrect in the April 2008 ASC DRUG file. The corrected payment rates are listed in Table 3 below and have been included in the revised April 2008 ASC DRUG file, effective for services furnished on April 1, 2008, through June 30, 2008. Suppliers who think they may have received an incorrect payment between April 1, 2008 through June 30, 2008, may request contractor adjustment of the previously processed claims.

Table 3-Updated Payment Rates for Certain HCPCS Codes Effective April 1, 2008 through June 30, 2008

HCPCS Code	Short Descriptor	Payment Indicator	Corrected Payment Rate
J1440	Filgrastim 300 mcg injection	K2	$197.37
J1441	Filgrastim 480 mcg injection	K2	$303.75
J2505	Injection, pegfilgrastim 6mg	K2	$2,179.44
J2788	Rho d immune globulin 50 mcg	K2	$26.06
J2790	Rho d immune globulin inj	K2	$83.63
J9050	Carmus bischl nitro inj	K2	$155.30

d. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

The payment rates for several HCPCS codes were incorrect in the July 2008 ASC DRUG file. The corrected payment rates are listed in Table 4 below and have been included in the revised October 2009 OPPS ASC DRUG file, effective for services furnished on July 1, 2008 through September 30, 2008. Suppliers who think they may have received an incorrect payment between July 1, 2008 through September 30, 2008, may request contractor adjustment of the previously processed claims.

Table 4-Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2008 through September 30, 2008

HCPCS Code	Short Descriptor	Payment Indicator	Corrected Payment Rate
J1438	Etanercept injection	K2	$172.44
J1440	Filgrastim 300 mcg injection	K2	$197.44
J1626	Granisetron HCl injection	K2	$5.28
J2505	Injection, pegfilgrastim 6mg	K2	$2,154.48
J2788	Rho d immune globulin 50 mcg	K2	$26.70
J2790	Rho d immune globulin inj	K2	$84.15
J9208	Ifosfomide injection	K2	$34.10
J9209	Mesna injection	K2	$7.86
J9226	Supprelin LA implant	K2	$14,463.26

e. Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2008 through December 31, 2008

The payment rates for several HCPCS codes were incorrect in the October 2008 ASC DRUG file. The corrected payment rates are listed in Table 5 below and have been included in the revised October 2009 OPPS ASC DRUG file, effective for services furnished on October 1, 2008 through December 31, 2008. Suppliers who think they may have received an incorrect payment between October 1, 2008 through December 31, 2008, may request contractor adjustment of the previously processed claims.

Table 5-Updated Payment Rates for Certain HCPCS Codes Effective October 1, 2008 through December 31, 2008

HCPCS Code	Short Descriptor	Payment Indicator	Corrected Payment Rate
J1441	Filgrastim 480 mcg injection	K2	$304.32
J2505	Injection, pegfilgrastim 6mg	K2	$2,175.85
J9209	Mesna injection	K2	$6.99
J9226	Supprelin LA implant	K2	$14,413.33
J9303	Panitumumab injection	K2	$81.86

f. Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009

The payment rates for several HCPCS codes were incorrect in the July 1, 2009 ASC DRUG file. The corrected payment rates are listed in Table 6 below and have been included in the revised October 2009 OPPS ASC DRUG file, effective for services furnished on July 1, 2009 through September 30, 2009. Suppliers who think they may have received an incorrect payment between July 1, 2009 through September 30, 2009, may request contractor adjustment of the previously processed claims.

Table 6-Updated Payment Rates for Certain HCPCS Codes Effective July 1, 2009 through September 30, 2009

HCPCS Code	Short Descriptor	Status Indicator	Corrected Payment Rate
90585	Bcg vaccine, percut	K2	$115.47
C9359	Implnt,bon void filler-putty	K2	$65.21
J9031	Bcg live intravesical vac	K2	$114.73
J9211	Idarubicin hcl injection	K2	$126.12
J9265	Paclitaxel injection	K2	$7.62
J9293	Mitoxantrone hydrochl / 5 MG	K2	$66.26
Q0179	Ondansetron hcl 8 mg oral	K2	$7.91

g. Correct Reporting of Drugs and Biologicals When Used As Implantable Devices

ASCs are not to bill separately for drug and biological HCPCS codes when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. As under the OPPS, ASCs are provided a packaged payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through

status. When using drugs and biologicals during covered surgical procedures as implantable devices, ASCs may include the charges for these items in their charge for the procedure.

h. Correct Reporting of Units for Drugs

ASCs are reminded to ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the drug's HCPCS code descriptor specifies 6 mg, and 6 mg of the drug were administered to the patient, the units billed should be 1. As another example, if the drug's HCPCS code descriptor specifies 50 mg, but 200 mg of the drug were administered to the patient, the units billed should be 4. ASCs should not bill the units based on how the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, 10 units should be reported on the bill, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

2. Manual Update to Pub. 100-04, Chapter 26

The CMS is updating Pub. 100-04, chapter 26, section 10.5 to remove a notation in the payment rate section of the table for item 24 – ASC. This update should have been included with the changes implemented in CR 6052, Transmittal 1604, dated September 26, 2008

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

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	
6629.1	Medicare contractors shall download and install the October 2009 ASC DRUG file FILENAME: MU00.@BF12390.ASC.CY09.DRUG.OCT.H.V0917 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
6629.2	Medicare contractors shall download and install a revised April 2008 ASC DRUG file FILENAME: MU00.@BF12390.ASC.CY08.DRUG.APR.H.V0917 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						

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	
6629.3	Medicare contractors shall download and install a revised July 2008 ASC DRUG file FILENAME: MU00.@BF12390.ASC.CY08.DRUG.JUL.H.V0917 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
6629.4	Medicare contractors shall download and install a revised October 2008 ASC DRUG file FILENAME: MU00.@BF12390.ASC.CY08.DRUG.OCT.H.V0917 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
6629.5	Medicare contractors shall download and install a revised July 2009 ASC DRUG file FILENAME: MU00.@BF12390.ASC.CY09.DRUG.JUL.H.V0917 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
6629.6	Medicare contractors shall download and install the October 2009 ASC PI file FILENAME: MU00.@BF12390.ASC.CY09.IND.V0917 **Date of retrieval will be provided in a separate email communication from CMS**	X			X						
6629.7	Contractors shall assign type of service (TOS) F to HCPCS codes Q2024 and Q4115 for claims with dates of service (DOS) on or after October 1, 2009.	X			X					X	
6629.8	Contractors shall adjust, as appropriate, claims brought to their attention with the following HCPCS codes J1440, J1441, J2505, J2788, J2790, J9050 for claims with	X			X						

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	
	DOS on or after April 1, 2008, but on or before June 30, 2008.										
6629.9	Contractors shall adjust, as appropriate, claims brought to their attention with the following HCPCS codes J1438, J1440, J1626, J2505, J2788, J2790, J9208, J9209, J9226 for claims with DOS on or after July 1, 2008, but on or before September 30, 2008.	X			X						
6629.10	Contractors shall adjust, as appropriate, claims brought to their attention with the following HCPCS codes J1441, J2505, J9209, J9226, J9303 for claims with DOS on or after October 1, 2008, but on or before December 31, 2008.	X			X						
6629.11	Contractors shall adjust, as appropriate, claims brought to their attention with the following HCPCS codes 90585, C9359, J9031, J9211, J9265, J9293, and Q0179 for claims with DOS on or after July 1, 2009, but on or before September 30, 2009.	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	
6629.12	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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin.	X			X						

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	
	Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

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

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): ASC Payment Policy: Chuck Braver at chuck.braver@cms.hhs.gov or 410-786-6719; Carrier/ AB MAC Claims Processing Issues: Yvette Cousar at yvette.cousar@cms.hhs.gov or 410-786-2160.
Post-Implementation Contact(s): Regional Office

VI. FUNDING

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

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.

10.5 - Place of Service Codes (POS) and Definitions

(Rev. 1806; Issued: 08-28-09; Effective Date: 10-01-09; Implementation Date: 10-05-09)

- 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).

- 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 of April 1, 2008. This code set has changed to include a new code, 16, for a temporary lodging setting, effective April 1, 2008.

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 *= New or revised code, or code not previously implemented by Medicare	**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) 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.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
06 Indian Health Service Provider-based Facility (January 1, 2003) A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA

outpatients. (See instructions below.)	
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 or injury on an ambulatory basis.	NF
12 Home Location, other than a hospital or other facility, where the patient receives care in a private residence.	NF
13 Assisted Living Facility (October 1, 2003) Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.	NF

14 Group Home (Code effective, October 1, 2003; description revised, effective April 1, 2004) A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).	NF
15 Mobile Unit (January 1, 2003) A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.	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**
17-19 Unassigned	--
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	F

diagnostic services are provided on an ambulatory basis.	
25 Birthing Center A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.	NF
26 Military Treatment Facility A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).	F
27-30 Unassigned	--
31 Skilled Nursing Facility A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.	F
32 Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	NF
33 Custodial Care Facility A facility which provides room, board and other personal assistance services, generally on a longterm basis, and which does not include a medical component.	NF
34 Hospice A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	F
35-40 Unassigned	--
41 Ambulance—Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F

42 Ambulance—Air or Water An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
43-48/Unassigned	--
49 Independent Clinic (October 1, 2003) A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.	NF
50 Federally Qualified Health Center A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.	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	NF

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.	
55 Residential Substance Abuse Treatment Facility A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	NF
56 Psychiatric Residential Treatment Center A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	F
57 Non-residential Substance Abuse Treatment Facility (October 1, 2003) A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	NF
58-59 Unassigned	--
60 Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media 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	NF

include physical therapy, occupational therapy, and speech pathology services.	
63-64 Unassigned	--
65 End-Stage Renal Disease Treatment Facility A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	NF
66-70 Unassigned	--
71 State or Local Public Health Clinic A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.	NF
72 Rural Health Clinic A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	NF
73-80 Unassigned	
81 Independent Laboratory A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	NF
82-98 Unassigned	
99 Other Place of Service Other place of service not identified above.	NF

- **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.

- **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.)

- **Paper Claims**

Adjudicate paper claims with codes from the National POS code set as you would for electronic claims. (Prior to HIPAA implementation, Medicare contractors were instructed to also apply these requirements to non-standard formats, effective January 1, 2003. However, it is not the purpose of instructions for this code set to determine how nonstandard formats are to be handled in a HIPAA environment, and this information should be expected from other instructions).