CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3315	**Date: August 6, 2015**
	Change Request 9231

SUBJECT: New and Revised Place of Service Codes (POS) for Outpatient Hospital

I. SUMMARY OF CHANGES: This Change Request revises the description of Place of Service (POS) code 22 to On Campus-Outpatient Hospital, and creates a new POS code for Off Campus-Outpatient Hospital.

EFFECTIVE DATE: January 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2016

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/20.4.2/Site of Service Payment Differential
R	12/30.6.1/ Selection of Level of Evaluation and Management Service
R	12/30.6.7/ Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215)
R	13/150/Place of Service (POS) Instructions for the Professional Component (PC or Interpretation) and the Technical Component (TC) of Diagnostic Tests
R	18/200.3/Professional Billing Requirements
R	26/Table of Contents
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/ Part B Medicare Administrative Contractor (MAC) Instructions for Place of Service (POS) Codes

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically

authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3315	Date: August 6, 2015	Change Request: 9231

SUBJECT: New and Revised Place of Service Codes (POS) for Outpatient Hospital

EFFECTIVE DATE: January 1, 2016
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I. GENERAL INFORMATION

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

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

This Change Request (CR) updates the current POS code set by adding new POS code 19 for "Off Campus-Outpatient Hospital" and revising POS code 22 from "Outpatient Hospital" to "On Campus-Outpatient Hospital." Also, this CR will implement the systems and local contractor level changes needed for Medicare to adjudicate claims with the new and revised codes. Local contractors shall develop policies as needed to adjudicate claims containing new POS code 19 and revised POS code 22 in accordance with Medicare national policy. Contractor editing shall treat POS 19 and POS 22 in the same way. See Title 42 CFR 413.65(a)(2) for a definition of "campus."

Payments for services provided to outpatients who are later admitted as inpatients within 3 days (or, in the case of non-IPPS hospitals, 1 day) are bundled when the patient is seen in a wholly owned or wholly operated physician practice. The 3-day payment window applies to diagnostic and nondiagnostic services that are clinically related to the reason for the patient's inpatient admission regardless of whether the inpatient and outpatient diagnoses are the same. The 3-day payment rule will also apply to services billed with POS code 19.

B. Policy: As discussed in the CY 2015 Physician Fee Schedule (PFS) final rule with comment period published on November 13, 2014 (79 FR 67572), in order to differentiate between on-campus and off-campus provider-based hospital departments, CMS is creating a new POS code (POS 19) and revising the current POS code description for outpatient hospital (POS 22) as follows:

<u>POS 19: Off Campus-Outpatient Hospital</u>

Descriptor: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

POS 22: On Campus-Outpatient Hospital

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

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

Claims for covered services rendered in an Off Campus-Outpatient Hospital setting, or in an On Campus-Outpatient Hospital setting, if payable by Medicare, shall be paid at the facility rate. The payment policies that currently apply to POS 22 will continue to apply and will now also apply to POS19 unless otherwise stated.

NOTE: This CR also makes minor corrections to POS codes 17 and 26 in the Internet Only Manual (IOM). POS 17 is paid the nonfacility rate. This notation was inadvertently removed from the POS code list in IOM Pub. 100-04, Chapter 26, section 10.5, and has now been restored. POS 26 (Military Treatment Facility) was inadvertently omitted from IOM Pub. 100-04, Chapter 12, section 20.4.2, and Chapter 26, section 10.5, and is now restored.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9231.1	Contractors shall be aware of and apply the changes in the manual instructions that revised the place of service (POS) code set and coding instructions.		X		X					
9231.2	Effective for claims processed on or after January 1, 2016, contractors shall recognize the revised description for place of service (POS) code 22 from "Outpatient Hospital" to "On Campus-Outpatient Hospital" described in Pub. 100-04, chapter 26, section 10.5.		X		X		X		X	COBA
9231.3	Effective for claims processed on or after January 1, 2016, contractors shall add POS 19 to the POS code set for "Off Campus-Outpatient Hospital" described in Pub. 100-04, chapter 26, section 10.5, applying business requirement numbers 4 through 7 (below) as appropriate.		X		X		X		X	COBA
9231.4	Contractors shall determine the policies applicable to POS code 19 within the constraints of applicable		X		X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	national Medicare laws, regulations, and other policies.									
9231.5	Contractors, if desired, may elect to create crosswalks of their local contractor policies in order to adjudicate claims with POS code 19.		X		X					
9231.6	Contractors shall adjudicate claims containing POS code 19 in accordance with its effective date and the policies they develop.		X		X					
9231.7	Contractors shall pay the facility rate for covered Medicare Physician Fee Schedule services that are payable in the off campus outpatient hospital setting.		X				X			
9231.8	Contractors shall educate physicians/practitioners and other suppliers to use, at a minimum, POS code 19 (Off Campus-Outpatient Hospital) or POS code 22 (On Campus-Outpatient Hospital) when they furnish services to an outpatient of a hospital, irrespective of where the face-to-face encounter occurs. (As discussed under "Special Considerations for Outpatient Hospital Departments" in Pub. 100-04, chapter 26, section 10.5.)		X							
9231.9	Contractors shall allow POS 19 to be billed for G0447 and G0473.		X						X	
9231.10	Until notified otherwise by CMS, for claims processed on or after January 1, 2016, contractors shall make any necessary systems changes to process procedure codes submitted with the revised POS code 22 and the new POS code 19 in the same way as they did for claims with 2015 dates of service submitted with POS 22.		X				X		X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9231.11	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X		X	

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Kathleen Kersell, 410-786-2033 or kathleen.kersell@cms.hhs.gov (Contact for policy questions.) , Tom Dorsey, 410-786-7434 or thomas.dorsey@cms.hhs.gov (Contact for practitioner claims processing questions.)

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

VI. FUNDING

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

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

20.4.2 - Site of Service Payment Differential
(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

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

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

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

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

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

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

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

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

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

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

30.6.1 - Selection of Level of Evaluation and Management Service

(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

A. Use of CPT Codes

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

B. Selection of Level of Evaluation and Management Service

Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the *Medicare Administrative Contractor (MAC)* at the appropriate physician fee schedule amount based on the rendering UPIN/PIN.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (refer to sections 60.1, 60.2, and 60.3, chapter 15 in IOM 100-02).

SPLIT/SHARED E/M SERVICE

Office/Clinic Setting

In the office/clinic setting when the physician performs the E/M service the service must be reported using the physician’s UPIN/PIN. When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS or CNM), the service is considered to have been performed “incident to” if the requirements for “incident to” are met and the patient is an established patient. If “incident to” requirements are not met for the shared/split E/M service, the service must be billed under the NPP’s UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.

Hospital Inpatient/Outpatient *(On Campus or Off Campus)*/Emergency Department Setting

When a hospital inpatient/hospital outpatient *(on campus-outpatient hospital or off campus outpatient hospital)* or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's UPIN/PIN number. However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient’s medical record) then the service may only be billed under the NPP's

UPIN/PIN. Payment will be made at the appropriate physician fee schedule rate based on the UPIN/PIN entered on the claim.

EXAMPLES OF SHARED VISITS

1. If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.

2. In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the “incident to” requirements are not met, the service must be reported using the NPP’s UPIN/PIN.

In the rare circumstance when a physician (or NPP) provides a service that does not reflect a CPT code description, the service must be reported as an unlisted service with CPT code 99499. A description of the service provided must accompany the claim. The *MAC* has the discretion to value the service when the service does not meet the full terms of a CPT code description (e.g., only a history is performed). The *MAC* also determines the payment based on the applicable percentage of the physician fee schedule depending on whether the claim is paid at the physician rate or the non-physician practitioner rate. CPT modifier -52 (reduced services) must not be used with an evaluation and management service. Medicare does not recognize modifier -52 for this purpose.

C. Selection of Level of Evaluation and Management Service Based On Duration of Coordination of Care and/or Counseling

Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient’s hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient’s care after the patient has left the office or the physician has left the patient’s floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

D. Use of Highest Levels of Evaluation and Management Codes

Contractors must advise physicians that to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT's definition of a comprehensive history).

The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient's medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.

The comprehensive examination may be a complete single system exam such as cardiac, respiratory, psychiatric, or a complete multi-system examination.

30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215)

(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

A. Definition of New Patient for Selection of E/M Visit Code

Interpret the phrase "new patient" to mean a patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3 year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

B. Office/Outpatient E/M Visits Provided on Same Day for Unrelated Problems

As for all other E/M services except where specifically noted, *the Medicare Administrative Contractors (MACs)* may not pay two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office*, off campus-outpatient hospital, or on campus-outpatient hospital* setting which could not be provided during the same encounter (e.g., office visit for blood pressure medication evaluation, followed five hours later by a visit for evaluation of leg pain following an accident).

C. Office/Outpatient or Emergency Department E/M Visit on Day of Admission to Nursing Facility

MACs may not pay a physician for an emergency department visit or an office visit **and** a comprehensive nursing facility assessment on the same day. Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician.

D. Drug Administration Services and E/M Visits Billed on Same Day of Service

MACs must advise physicians that CPT code 99211 cannot be paid if it is billed with a drug administration service such as a chemotherapy or nonchemotherapy drug infusion code (effective January 1, 2004). This drug administration policy was expanded in the Physician Fee Schedule Final Rule, November 15, 2004, to also include a therapeutic or diagnostic injection code (effective January 1, 2005). Therefore, when a medically necessary, significant and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25. Documentation should support the level of E/M service billed. For an E/M service provided on the same day, a different diagnosis is not required.

Medicare Claims Processing Manual
Chapter 13 - Radiology Services and Other Diagnostic Procedures

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

(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

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 the ASC X12 837 professional claim format or in item 24B on the paper claim Form CMS 1500. In cases where it is unclear which POS code applies, the Medicare contractor can provide guidance.

For example: A beneficiary receives an MRI *on* an outpatient hospital *campus* 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 (*On Campus-* 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, *on the campus of an* 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 *On Campus-*

*O*utpatient *H*ospital, *or POS 19, for Off Campus-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 on the ASC X12 837 professional claim format or in Item 32 on the paper claim Form CMS 1500.

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 using the ASC X12 837 professional claim format or in Item 32 on the paper claim Form CMS 1500. 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 using the ASC X12 837 professional claim format or in Item 32 on the paper claim Form CMS 1500.

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

200.3 – Professional Billing Requirements
(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, (G0447), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when services are submitted by the following provider specialties found on the provider's enrollment record:

01 - General Practice
08 - Family Practice
11 - Internal Medicine
16 - Obstetrics/Gynecology
37 - Pediatric Medicine
38 - Geriatric Medicine
50 - Nurse Practitioner
89 - Certified Clinical Nurse Specialist
97 - Physician Assistant

Any claims that are not submitted from one of the provider specialty types noted above will be denied.

CMS will allow coverage for Face-to-Face Behavioral Counseling for Obesity, 15 minutes, (G0447), Face-to-face behavioral counseling for obesity, group (2-10), 30 minute(s) (G0473), along with 1 of the ICD-9 codes for BMI 30.0-BMI 70 (V85.30-V85.39 and V85.41-V85.45), only when submitted with one of the following place of service (POS) codes:

11 – Physician's Office
19 – Off Campus-Outpatient Hospital
22 – *On Campus-*Outpatient Hospital
49 – Independent Clinic
71 – State or Local Public Health Clinic

Any claims that are not submitted with one of the POS codes noted above will be denied.

NOTE: HCPCS Code G0447 is effective November 29, 2011. HCPCS Code G0473 is effective January 1, 2015.

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

Table of Contents
(Rev. 3315, 08-06-15)

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

(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

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.

Additional information for form version 02/12: Although this version of the form includes space for a qualifier, Medicare does not use this information; do not enter a qualifier in item 14.

Item 15 - Leave blank.

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. Similarly, if Medicare policy requires you to report a supervising physician, enter this information in item 17. When a claim involves multiple referring, ordering, or supervising physicians, use a separate CMS-1500 claim form for each ordering, referring, or supervising physician.

Additional instructions for form version 02/12: Enter one of the following qualifiers as appropriate to identify the role that this physician (or non-physician practitioner) is performing:

Qualifier	Provider Role
DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

Enter the qualifier to the left of the dotted vertical line on item 17.

NOTE: Under certain circumstances, Medicare permits a non-physician practitioner to perform these roles. Refer to Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Enter non-physician practitioner information according to the rules above for physicians.

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 – Enter the NPI of the referring, ordering, or supervising physician or non-physician practitioner listed in item 17. All physicians and non-physician practitioners 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 provider identifiers submitted on the CMS-1500 claim form 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 A/B MAC (B) 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 a 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," 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 provider identifiers submitted on the CMS-1500 claim form 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 A/B MACs (B) 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 diagnosis codes to the highest level of specificity for the date of service. Enter the diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Reminder: Do not report ICD-10-CM codes for claims with dates of service prior to implementation of ICD-10-CM, on either the old or revised version of the CMS-1500 claim form.

For form version 08/05, report a valid ICD-9-CM code. Enter up to four diagnosis codes.

For form version 02/12, it may be appropriate to report either ICD-9-CM or ICD-10-CM codes depending upon the dates of service (i.e., according to the effective dates of the given code set).

- The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable ICD indicator according to the following:

Indicator	Code Set
9	ICD-9-CM diagnosis
0	ICD-10-CM diagnosis

  Enter the indicator as a single digit between the vertical, dotted lines.

- Do not report both ICD-9-CM and ICD-10-CM codes on the same claim form. If there are services you wish to report that occurred on dates when ICD-9-CM codes were in effect, and others that occurred on dates when ICD-10-CM codes were in effect, then send separate claims such that you report only ICD-9-CM or only ICD-10-CM codes on the claim. (See special considerations for spans of dates below.)

- If you are submitting a claim with a span of dates for a service, use the "from" date to determine which ICD code set to use.

- Enter up to 12 diagnosis codes. Note that this information appears opposite lines with letters A-L. Relate lines A- L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

- Do not insert a period in the ICD-9-CM or ICD-10-CM code.

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 CMS-1500 claim form.

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 *(off campus or on campus)* of a hospital, use the inpatient hospital POS code 21, *Off Campus-Outpatient Hospital POS code 19,* or *On Campus-O*utpatient *H*ospital 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 CMS-1500 claim form has the capacity 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 a NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E – This is a required field.
Enter the diagnosis code reference number or letter (as appropriate, per form version) as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number/letter per line item. When multiple services are performed, enter the primary reference number/letter for each service.

When using form version 08/05, this reference will be either a 1, or a 2, or a 3, or a 4.

When using form version 02/12, the reference to supply in 24E will be a letter from A-L. Otherwise, the instructions above apply.

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 A/B MAC (B) 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, enter 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, 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 CMS-1500 claim form 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 A/B MAC (B) 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 CMS-1500 claim form 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.

Effective for claims submitted with a receipt date on and after October 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier on the claim on reference laboratory claims, even if the performing physician or supplier is enrolled in a different A/B MAC (B) jurisdiction. See Pub. 100-04, Chapter 1, §10.1.1 for more information regarding claims filing jurisdiction.

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 - Item 33b is not generally reported. However, for some Medicare policies you may be instructed to use this item; direction as to how to use this item will be in the instructions you received regarding the specific policy, if applicable.

10.5 - Place of Service Codes (POS) and Definitions

(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

- HIPAA

  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) became effective October 16, 2003, for all covered entities. Medicare is a covered entity under HIPAA.

  - The final rule, "Health Insurance Reform: Standards for Electronic Transactions," published in the **Federal Register**, August 17, 2000, adopts the standards to be used under HIPAA and names the implementation guides to be used for these standards. The ASC X12N 837 professional is the standard to be used for transmitting health care claims electronically, and its implementation guide requires the use of POS codes from the National POS code set, currently maintained by CMS.

  - As a covered entity, Medicare must use the POS codes from the National POS code set for processing its electronically submitted claims. Medicare must also recognize as valid POS codes from the POS code set when these codes appear on such a claim.

  - Medicare must recognize and accept POS codes from the national POS code set in terms of HIPAA compliance. Note special considerations for Homeless Shelter (code 04), Indian Health Service (codes 05, 06), Tribal 638 (codes 07, 08), and 09 Prison/Correctional Facility settings, described below. Where there is no national policy for a given POS code, local contractors may work with their medical directors to develop local policy regarding the services payable in a given setting, and this could include creating a crosswalk to an existing setting if desired. However, local contractors must pay for the services at either the facility or the nonfacility rate as designated below. In addition, local contractors, when developing policy, must ensure that they continue to pay appropriate rates for services rendered in the new setting; if they choose to create a crosswalk from one setting to another, they must crosswalk a facility rate designated code to another facility rate designated code, and a nonfacility rate designated code to another nonfacility rate designated code. For previously issued POS codes for which a crosswalk was mandated, and for which no other national Medicare directive has been issued, local contractors may elect to continue to use the crosswalk or develop local policy regarding the services payable in the setting, including another crosswalk, if appropriate. If a local contractor develops local policy for these settings, but later receives specific national instructions for these codes, the local contractors shall defer to and comply with the newer instructions. (**Note**: While, effective January 1, 2003, codes 03 School, 04 Homeless Shelter, and 20 Urgent Care became part of the National POS code set and were to be crosswalked to 11 Office, this mandate to crosswalk has since been lifted, as indicated above).

  - National policy in the form of "Special Considerations" for *Off Campus-Outpatient Hospital (POS 19),* Inpatient Hospital (POS code 21), *On Campus*-Outpatient Hospital (POS code 22), Ambulatory Surgical Center (POS code 24) and Hospice (POS code 34) are included below.

- The National POS Code Set and Instructions for Using It

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

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

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
01 Pharmacy (October 1, 2005) A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.	NF
02 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 *"Special Considerations"* below.)	NF
05 Indian Health Service Free-standing Facility (January 1, 2003) A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization. (See *"Special Considerations"* below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
06 Indian Health Service Provider-based Facility (January 1, 2003) A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (See *"Special Considerations"* below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
07 Tribal 638 Free-Standing Facility (January 1, 2003) A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization. (See *"Special Considerations"* 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.	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
(See *"Special Considerations"* below.)	
09 Prison/Correctional Facility (July 1, 2006) A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (See *"Special Considerations"* below.)	NF
10 Unassigned	--
11 Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	NF
12 Home Location, other than a hospital or other facility, where the patient receives care in a private residence.	NF
13 Assisted Living Facility (October 1, 2003) Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.	NF
14 Group Home (Code effective, October 1, 2003; description revised, effective April 1, 2004) A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).	NF
15 Mobile Unit (January 1, 2003) A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services. *(See "Special Considerations" below.)*	NF
16 Temporary Lodging (April 1, 2008) 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.	NF

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

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

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

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

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

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

  Note that for the purposes of receiving durable medical equipment (DME), a homeless shelter is considered the beneficiary's home. Because DME is payable in the beneficiary's home, the crosswalk for Homeless Shelter (code 04) to Office (code 11) that was mandated effective January 1, 2003, may need to be adjusted or local policy developed so that HCPCS codes for DME are covered when other conditions are met and the beneficiary is in a homeless shelter. If desired, local contractors are permitted to work with their medical directors to determine a new crosswalk such as from Homeless Shelter (code 04) to Home (code 12) or Custodial Care Facility (code 33) for DME provided in a homeless shelter setting. If a local contractor is currently paying claims correctly, however, it is not necessary to change the current crosswalk.

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

  Medicare does not currently use the POS codes designated for these settings. Follow the instructions you have received regarding how to process claims for services rendered in IHS and Tribal 638

settings. If you receive claims with these codes, you must initially accept them in terms of HIPAA compliance. However, follow your “return as unprocessable” procedures after this initial compliance check. Follow your “return as unprocessable" procedures when you receive paper claims with these codes. (Note that while these codes became part of the National POS code set effective January 1, 2003, Medicare contractors received instructions regarding how to process claims with these codes effective October 1, 2003, so that Medicare could be HIPAA compliant by October 16, 2003).

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

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

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

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

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

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

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

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

  When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF

receiving inpatient skilled nursing care, POS 51, for a patient registered in a Psychiatric Inpatient Facility, and POS 61 for patients registered in a Comprehensive Inpatient Rehabilitation Facility.

- **Special Considerations for Outpatient Hospital Departments**

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

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

  NOTE: Physicians/practitioners who perform services in a hospital outpatient department shall use, at a minimum, *POS code 19 (Off Campus-Outpatient Hospital) or* POS code 22 (*On Campus*-Outpatient Hospital). Code *19 or* 22 (or other appropriate outpatient department POS code as described above) shall be used unless 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., *off campus-outpatient hospital (POS 19) or on campus*-outpatient hospital (POS 22)), the patient's physician or nonphysician practitioner or hospice independent attending physician or nurse practitioner, shall assign the POS code that represents that setting, as appropriate.

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

- **Paper Claims**

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

10.6 – *Part B Medicare Administrative Contractor (MAC)* Instructions for Place of Service (POS) Codes

(Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

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 *19 or* 22*, for outpatient services performed off campus or on campus*) 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 *Medicare Administrative Contractors (MACs)* 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 an inpatient or outpatient of a hospital, it uses the code for the inpatient (POS code 21), *off campus-outpatient hospital (POS code 19),* or *on campus-*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 *MAC* 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 *MAC* 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.