

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 485	Date: MAY 1, 2009
	Change Request 6442

SUBJECT: Implementation -- Systems Improvements to Streamline Updates to the Place of Service (POS) Code Set

I. SUMMARY OF CHANGES: The changes specified in this instruction will streamline the existing process for updating the Place of Service (POS) Code Set by allowing contractors to add, update, copy and delete records without necessitating a shared systems change.

NEW / REVISED MATERIAL

EFFECTIVE DATE: *October 1, 2009

IMPLEMENTATION DATE: October 5, 2009

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
N/A	

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

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

SECTION B: For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 485	Date: May 1, 2009	Change Request: 6442
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SUBJECT: Implementation --- Systems Improvements to Streamline Updates to the Place of Service (POS) Code Set

Effective Date: October 1, 2009

Implementation Date: October 5, 2009

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 professional claim format standard requires that each electronic claim transaction include a 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 code from the POS code set.

Medicare must streamline the updating process to promote the prompt, efficient adoption of new POS codes so that Medicare can comply with HIPAA with minimal strain on the implementation of other program needs.

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 fee-for-service program does not always have the same need for setting specificity as other CMS programs, such as Medicaid, adjudicating the claims with the full range of POS codes eases the coordination of benefits for Medicaid and other payers who may need the specificity afforded by the entire POS code set.

On June 6, 2008, CMS issued CR 6066 (Transmittal 347, Pub. 100-20) to instruct the Common Working File (CWF) maintainer to identify the design considerations needed to streamline the process for making updates to the POS code set. In addition, the CR directed the shared system maintainers and the contractors to perform an analysis of the CWF POS code set edits to determine which edits needed to be modified or deactivated. The results of the analysis done in CR 6066 will be implemented in this instruction (See Attachment A).

B. Policy:

The CWF maintainer shall implement the design considerations identified in CR 6066. The shared system maintainers and contractors shall implement the recommendations that they noted as a result of the analysis done for CR 6066 by modifying or deactivating the POS code set edits specified in this instruction. The deactivation of the edits will be done by process date.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
6442.1	The shared system maintainers and the contractors shall deactivate the following Consistency POS code set edits: 59x2 62x2 62x7 62x8 77x1 77x3 77x6 78x8		X						X	X
6442.2	The shared system maintainers and the contractors shall deactivate the following Utilization POS code set edits: 5507 C029		X						X	X
6442.2.1	The shared system maintainer shall remove the prepass editing logic that mirrors POS code set edit C029 once it has been deactivated.							X		
6442.3	The shared system maintainers and contractors shall keep the following Part B Consistency POS code set edit active: 62x1	X			X					X
6442.4	The shared system maintainers and contractors shall keep the following Part B Utilization POS code set edits active: 524J 524K 524L 524M 524N	X			X					X
6442.5	For the CWF edits to be deactivated, contractors shall refer to Attachment A to determine which of these edits the contractors can accomplish in their own operations. For all instances where the attachment indicates that the local contractors can achieve the purpose of the given CWF edit to be deactivated, the contractors shall assume responsibility for such edits and shall ensure	X	X		X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D / M	F / I	C / R	R / H	Shared-System Maintainers				OT H ER
		M / A / C	M / A / C		R / I / E / R	I / S / S	F / I / S	M / C / S	V / M / S	C / W / F	
	that they have edits for these purposes functioning within their operations. Note that references to "carriers" and "Pt. B Carriers" in Attachment A also encompass and apply to A/B MACs.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D / M	F / I	C / R	R / H	Shared-System Maintainers				OT H ER
		M / A / C	M / A / C		R / I / E / R	I / S / S	F / I / S	M / C / S	V / M / S	C / W / F	
	None.										

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): For DME MACs : Tracey Herring, (410) 786-7169 or Tracey.Herring@cms.hhs.gov

For B MACs: Claudette Sikora, (410) 786-5618 or Claudette.Sikora@cms.hhs.gov; For CWF issues: Kathy Woytan, (410) 786-4982 or Kathryn.Woytan@cms.hhs.gov

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

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

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

Section B: For *Medicare Administrative Contractors (MACs)*, include the following statement:

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.

Attachment

Attachment A -- CR6066: Analysis Results

<u>CWF edits that Read POS</u>	<u>CWF's Comments Pre Quarterly Release Document (07/22/2008)</u>	<u>ViPS' Comments</u>
<p><u>59x2</u> Invalid Type of Service for Ambulatory Surgical Care Place of Service.</p> <p>Type of Record: Pt. B Carrier</p> <p>When the Place of Service is equal to '24', and when Type of Service is not equal to '1-9', 'A', 'F', 'I', 'J', 'K', 'L', 'P', 'Q', 'R', 'S', 'T', 'V', 'Y', or 'Z', set the '59x2' error code.</p> <p>When the From Date is equal to zeros, or the CMS Payment Process Indicator is equal to 'T', bypass this edit.</p> <p>When the claim or line item is denied, bypass this edit.</p>	<p>Deactivate</p> <p>Carrier can determine which services are ASC related</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>
<p><u>62x1</u> Invalid Reimbursement Indicator.</p> <p>Type of Record: Pt. B Carrier and DMEPOS</p> <p>When the CMS Reimbursement Indicator is not equal to '0', '1', '2', or '3', set the '62x1' error code.</p> <p>When the From Date is greater than 09/30/1982 and the CMS Reimbursement Indicator is equal to '1', and the CMS Deductible Indicator is not equal to '0', set the '62x1' error code.</p>	<p>Do not deactivate</p> <p>Incoming claim must contain a valid payment indicator. The Place of Service bypass is incidental (not the primary focus of the edit).</p>	<p>ViPS agrees that for this edit, place of service is incidental and not the primary focus of the edit.</p>

<p>When the claim or line item is denied, bypass this edit.</p> <p>When the Place of Service is not equal to '99' (other), or the CMS Type of Service is not equal to 'A', bypass this edit.</p> <p>When the claim is denied, bypass this edit.</p> <p>When the CMS Payment Process Indicator is equal to 'T', bypass this edit.</p>		
<p><u>62x2</u> Place of Service '99' (Other) for Type of Service 'A' (Used DME) for Dates of Service between 09/30/1982 and 01/01/1989 must have a Reimbursement Indicator of '1' (100%) and Deductible Indicator of '0' (subject to deductible).</p> <p>Type of Record: Pt. B Carrier and DMEPOS</p> <p>When the From Date is greater than 09/30/1982, and the From Date is less than 01/01/1989, and the CMS Reimbursement Indicator is not equal to '1', and the CMS Deductible Indicator is not equal to '0', set the '62x2' error code.</p> <p>When the Place of Service is not equal to '99' (other), or the CMS Type of Service is not equal to 'A', bypass this edit.</p> <p>When the claim or line item is denied, bypass this edit.</p> <p>When the From Date is equal to zeros, or the CMS Payment</p>	<p>Deactivate</p> <p>Dates specified in the edit are obsolete, they are almost 10 years old.</p>	<p>ViPS agrees with CWF's comment regarding the dates. We also believe that for this edit (as with 62x1 above), place of service is incidental and not the primary focus of the edit.</p>

<p>Process Indicator is equal to 'T', bypass this edit.</p>		
<p><u>62x7</u> Place of Service '24'(Ambulatory Surgery Center) must have a Reimbursement Indicator of '1' (100%) and a Deductible Indicator of '1' (not subject to deductible.). Claim Dates of Service must be prior to 04/01/1988.</p> <p>Type of Record: Pt. B Carrier</p> <p>When the From Date is equal to zeros, or the CMS Payment Process Indicator is equal to 'T', bypass this edit.</p> <p>When the Place of Service is equal to '24' (Ambulatory Surgical Center), and the From Date is less than 04/01/1988, and the Reimbursement Indicator is equal to '1', and the Deductible Indicator is equal to '0', set the '62x7' error code.</p> <p>When the claim or line item is denied, bypass this edit.</p>	<p>Deactivate</p> <p>Dates specified in the edit are obsolete, they are almost 20 years old.</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>
<p><u>62x8</u> Type of Service 'N' (Kidney Donor) or Modifier 'Q3' must have a Reimbursement Indicator of '1' (100%) and a Deductible Indicator of '1' (not subject to deductible).</p> <p>Type of Record: Pt. B Carrier</p> <p>When the Type of Service is equal to 'N', and the Reimbursement Indicator is not equal to '1', and the Deductible Indicator is not equal to '0', set the '62x8' error code.</p>	<p>Deactivate</p> <p>Carrier can determine if kidney services have deductible or co-insurance applied and if the services are being performed in ASC</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>

<p>When the Type of Service is not equal to 'N', and Procedure Code Modifier '1', '2', '3', or '4' is equal to 'Q3' and the Reimbursement Indicator is not equal to '1', and the Deductible Indicator is not equal to '0', set the '62x8' error code.</p> <p>When the From Date is equal to zeros, or the CMS Payment Process Indicator is equal to 'T', bypass this edit.</p> <p>When the Place of Service is not equal to '24' (Ambulatory Surgical Center), bypass this edit.</p> <p>When the claim or line item is denied, bypass this edit.</p>		
<p><u>77x1</u> Invalid Place of Service.</p> <p>Type of Record: Pt. B Carrier and DMEPOS</p> <p>When the Place of Service is not equal to:</p> <ul style="list-style-type: none"> '01' Pharmacy '03' School '04' Homeless Shelter '05' Indian Health Service Free-standing Facility '06' Indian Health Service Provider-based Facility '07' Tribal 638 Free-standing Facility '08' Tribal 638 Provider-based Facility '11' Office '12' Home '13' Assisted Living Facility '14' Group Home '15' Mobile Unit 	<p>Deactivate</p> <p>Carrier/DMAC can use the Place of Service Code set.</p>	<p>Within VMS online claim processing, the Place of Service on the claim line is validated against the Place of Service codes set (VMAP/4C/POSTABLE – Place of Service Table). Online claim edit 1010 prompts when the POS on the claim line does not match one of the values on the POSTABLE.</p> <p>NOTE: ViPS noticed that places of service 09 and 16 were not included as valid values for this CWF edit as written in the CR; however, we checked the most current CWF documentation for this edit and these values are included as valid.</p>

<p>'20' Outpatient Hospital '21' Inpatient Hospital '22' Outpatient Hospital '23' Emergency Room Hospital '24' Ambulatory Surgical Center '25' Birthing Center '26' Military Treatment Center '31' Skilled Nursing Facility '32' Nursing Facility '33' Custodial Care Facility '34' Hospice '41' Ambulance - Land '42' Ambulance - Air or Water '49' Independent Clinic '50' Federally Qualified Health Center '51' Inpatient Psychiatric Facility '52' Psychiatric Facility Partial Hospitalization '53' Community Mental Health Center '54' Intermediate Care Facility/Mentally Retarded '55' Substance Abuse Treatment Facility '56' Psychiatric Treatment Facility '57' Non-residential Substance Abuse Treatment Facility '60' Mass Immunization Center '61' Comprehensive Inpatient Rehabilitation Facility '62' Comprehensive Outpatient Rehabilitation Facility '65' End Stage Renal Disease Treatment '71' Public Health Clinic '72' Rural Health Clinic '81' Independent Laboratory or '99' Other Unlisted Facility, set the '77x1' error code.</p>		
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<p>When the Payment Process Indicator is equal to 'I', bypass this edit.</p> <p>When the Payment Process Indicator is equal to 'O', bypass this edit.</p>		
<p><u>77x3</u> Physician Specialty '65' (Physical Therapy) performing Service Type '9' (Other Medical) or 'A' (Used DME) must be performed at Place of Service.</p> <p>Type of Record: Pt. B Carrier</p> <p>When the Provider Specialty is equal to '65', and the Type of Service is equal to '9' or 'A', and the Place of Service is not equal to:</p> <ul style="list-style-type: none"> '03' School '04' Homeless Shelter '05' Indian Health Service Free-standing facility '06' Indian Health Service Provider-based facility '07' Tribal '638' Freestanding Facility '08' Tribal '638' Provider-based Facility '11' Office '12' Home '13' Assisted Living Facility '14' Group Home '15' Mobile Unit '20' Outpatient Hospital '25' Birthing Center '26' Military Treatment Center '32' Nursing Facility 	<p>Deactivate</p> <p>Carrier can determine if the physician specialty is 65, and if the services are being performed in a valid place of service</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>

<p>'33' Custodial Care Facility '49' Independent Clinic '54' Intermediate Care Facility/Mentally Retarded '55' Substance Abuse Treatment Facility '56' Psychiatric Treatment Facility '57' Non-residential Substance Abuse Treatment Facility '71' Public Health Clinic '72' Rural Health Clinic, set the '77x3' error code.</p> <p>When the claim or line item is denied, bypass this edit.</p> <p>When the From Date is equal to zeros, or the Payment Process Indicator is equal to 'I', bypass this edit.</p> <p>When the Type of Service is equal to 'W', bypass this edit.</p>		
<p><u>77x6</u> Place of Service must be '24' (Ambulatory Surgical Center) for Type of Service of 'F'.</p> <p>Type of Record: Pt. B Carrier and DMEPOS</p> <p>When the Type of Service is equal to 'F' and the Place of Service is not equal to '24' (Ambulatory Surgical Center), set the '77x6' error code.</p> <p>When the claim or line item is denied, bypass this edit.</p> <p>When the Payment Process Indicator is equal to 'I', bypass this edit.</p>	<p>Deactivate</p> <p>Carrier can determine if TOS F is submitted on claim with POS 24</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>

<p><u>78x8</u> From Date is prior to 09/01/1982 for '24' (Ambulatory Service Center Place) of Service.</p> <p>Type of Record: Pt. B Carrier</p> <p>When the Place of Service is equal to '24' (Ambulatory Surgical Center) and the From Date is less than 09/01/1982, set the '78x8' error code.</p> <p>When the claim or line item is denied, bypass this edit.</p> <p>When the From Date is equal to zeros, or the CMS Payment Process Indicator is equal to 'T', bypass this edit.</p>	<p>Deactivate</p> <p>Service Date prior to 9/1/82 for ASC, that is more than 20 years ago.</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>
<p><u>524J</u> A claim with POS '21', '22', or '23' with no Site of Service ID# and either Service From or Thru Date either matches the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date or if no Discharge Date but on or after the Admit Date on the Auxiliary file.</p> <p>Type of Record: Pt. B Carrier</p> <p>When a Part B claim is submitted with Place of Service of '21'-Inpatient Hospital, '22'-Outpatient Hospital, or '23'-Emergency Room-Hospital, and is a Fee for Service claim, not Demo '07' or '08' or Pay Denial Code is equal to 'D', and Site of Service ID is equal to spaces or low-values,</p>	<p>Do not deactivate</p> <p>Edit is set based on Aux File in CWF</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>

<p>AND</p> <p>If the First Expense Date on the incoming claim is equal to Admit Date on the Admission Period, Demo '07' or '08', of the CEPP Aux file, set the '524J' error code.</p> <p>If the First Expense Date on the incoming claim is equal to Discharge Date on the Admission Period, Demo '07' or '08', of the CEPP Aux file, set the '524J' error code.</p> <p>If the Last Expense Date on the incoming claim is equal to Admit Date on the Admission Period, Demo '07' or '08', of the CEPP Aux file, set the '524J' error code.</p> <p>If the Last Expense Date on the incoming claim is equal to Discharge Date on the Admission Period, Demo '07' or '08', of the CEPP Aux file, set the '524J' error code.</p> <p>If Discharge Date is equal to '0' on the Admission Period, Demo '07' or '08', of the CEPP Aux file,</p> <p>AND</p> <p>If the First Expense Date on the incoming claim is equal to or greater than the Admit Date on the Admission Period, Demo '07' or '08', of the CEPP Aux file, set the '524J' error code.</p> <p>If the Last Expense Date on the incoming claim is equal to or greater than the Admit Date on the Admission Period, Demo '07' or '08', of the CEPP Aux file, set the '524J' error code.</p>		
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<p>Entry Code is equal to '3', bypass this edit.</p> <p>Demo Number '07' or '08' with a Denial Code of 'D' is present on the incoming claim, bypass this edit.</p>		
<p><u>524K</u> A claim for POS '21', '22', or '23' with no Site of Service ID# and either First Expense Date is between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date but not equal to the Discharge Date on the Auxiliary file,</p> <p>OR</p> <p>Last Expense Date is between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date but not equal to the Admit Date on the Auxiliary file.</p> <p>Type of Record: Pt. B Carrier</p> <p>When a Part B claim is submitted with Place of Service of '21'-Inpatient Hospital, '22'-Outpatient Hospital, or '23'-Emergency Room-Hospital, and is a Fee for Service claim, not Demonstration Number '07' or '08' or Pay Denial Code is equal to 'D', and Site of Service ID is equal to spaces or low-values,</p> <p>AND</p> <p>If the First Expense Date on the incoming claim is between the Admit and Discharge Date but not equal to Discharge Date on</p>	<p>Do not deactivate</p> <p>Edit is set based on Aux File in CWF</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>

<p>the Admission Period, Demo '07' or '08', of the CEPP Aux file, set the '524K' error code.</p> <p>If the Last Expense Date on the incoming claim is between the Admit and Discharge Date but not equal to Admit Date on the Admission Period, Demo '07' or '08', of the CEPP Aux file, set the '524K' error code.</p> <p>Entry Code is equal to '3', bypass this edit.</p> <p>Demo Number '07' or '08' with a Denial Code of 'D' is present on the incoming claim, bypass this edit.</p>		
<p><u>524L</u> A claim for POS '21', '22', or '23' and the Site of Service ID# on the record does match the Participating Centers of Excellence or Provider Partnership's Provider Number on the Auxiliary file and either First Expense Date is on or between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date on the Auxiliary file.</p> <p>OR</p> <p>Last Expense Date is on or between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date on the Auxiliary file.</p> <p>Type of Record: Pt. B Carrier</p> <p>If a Part B claim is submitted with Place of Service of '21'-</p>	<p>Do not deactivate</p> <p>Edit is set based on Aux File in CWF</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>

<p>Inpatient Hospital, '22'-Outpatient Hospital, or '23'-Emergency Room-Hospital, and is a Fee for Service claim, not Demonstration Number '07' or '08' or Pay Denial Code is equal to 'D', and the positions 4 thru 16 (13 positions) of the Site of Service ID on the incoming claim is equal to the Provider Number on the Admission Period, Demo '07' or '08', of the CEPP Aux file, and if the First Expense Date on the incoming claim is equal to the Admit Date or the Discharge Date on the Admission Period OR between the Admit and Discharge Dates of the CEPP Aux file, set the '524L' error code.</p> <p>If a Part B claim is submitted with Place of Service of '21'- Inpatient Hospital, '22'- Outpatient Hospital, or '23'-Emergency Room-Hospital, and is a Fee for Service claim, not Demonstration Number '07' or '08' or Pay Denial Code is equal to 'D', and the positions 4 thru 16 (13 positions) of the Site of Service ID on the incoming claim is equal to the Provider Number on the Admission Period, of the CEPP Aux file, and if the Last Expense Date on the incoming claim is equal to the Admit Date or the Discharge Date on the Admission Period, OR between the Admit and Discharge Dates on the Admission Period, Demonstration Number '07' or '08', of the CEPP Aux file, set the '524L' error code.</p> <p>If the Entry Code is equal to '3', bypass this edit.</p> <p>If Demo Number '07' or '08' with a Denial Code of 'D' is present on the incoming claim, bypass this edit.</p>		
<p>524M A claim with POS '21', '22', or '23' and the Site of Service</p>	<p>Do not deactivate</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion</p>

<p>ID# on the record does not match the Participating Centers of Excellence or Provider Partnership's Provider Number on the Auxiliary file and either First Expense Date is between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date but not equal to the Discharge Date on the Auxiliary file,</p> <p>OR</p> <p>Last Expense Date is between the Participating Centers of Excellence or Provider Partnership's Admit Date or Discharge Date but not equal to the Admit Date on the Auxiliary file.</p> <p>Type of Record: Pt. B Carrier</p> <p>When a Part B claim is submitted with Place of Service of '21'-Inpatient Hospital, '22'-Outpatient Hospital, or '23'-Emergency Room-Hospital, and is a Fee for Service claim, and there is no Demonstration Number '07' or '08' or Pay Denial Code equal to 'D' on the incoming claim, and positions 4 thru 16 of the Site of Service ID on the incoming claim is different from the Provider Number on the Admission Period for either Centers of Excellence or Provider Partnership, on the CEPP Aux file, and if the First or Last Expense Date on the incoming claim is between the Admit and Discharge Date but not equal to Discharge Date on the Admission Period on the CEPP Aux file, set the '524M' error code.</p> <p>If the Entry Code is equal to '3', bypass this edit.</p>	<p>Edit is set based on Aux File in CWF</p>	<p>that this edit does not apply to DME processing.</p>
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<p>If Demo Number '07' or '08' with a Denial Code of 'D' is present on the incoming claim, bypass this edit.</p> <p>If Discharge Date on the Admission Period, Demo '07' or '08', of the CEPP Aux file is equal to '0', bypass this edit.</p>		
<p><u>524N</u> A claim with POS '21', '22', or '23' with no Site of Service ID# and the First and Last Expense Dates overlaps more than one open Admission period on the Participating Centers of Excellence or Provider Partnership's Auxiliary file.</p> <p>Type of Record: Pt. B Carrier</p> <p>If a Part B claim is submitted with Place of Service of '21'-Inpatient Hospital, '22'-Outpatient Hospital, or '23'-Emergency Room-Hospital, and is a Fee for Service claim, and does not have Demonstration Number '07' or '08' or Pay Denial Code equal to 'D' present on the claim, and Site of Service ID is equal to spaces or low-values, and the two adjacent Admission Periods on the CEPP Aux file have Discharge Dates equal to '0', and the Last Expense Date is after the Admit Date of the first Admission Period on the CEPP Aux file, and the First Expense Date is less than or equal to the Admit Date of the second Admission Period on the CEPP Aux file, set the '524N' error code.</p> <p>The Entry Code is equal to '3', bypass this edit.</p> <p>If Demo Number '07' or '08' with a Denial Code of 'D' is present</p>	<p>Do not deactivate</p> <p>Edit is set based on Aux File in CWF</p>	<p>Based on the criteria provided by CWF for this edit, it is ViPS' opinion that this edit does not apply to DME processing.</p>

<p>on the incoming claim, bypass this edit.</p>		
<p><u>5507</u> Place of Service is other than the Beneficiary's residence.</p> <p>Type of Record: DMEPOS</p> <p>When the claim line item Place of Service is not equal to 04 - Homeless Shelter 12 - Home 13 - Assisted Living Facility 14 - Group Home 31 - Skilled Nursing Facility 32 - Nursing Facility 33 - Custodial Care Facility 54 - Intermediate Care Facility/Mentally Retarded, set the '5507' error code.</p> <p>When the claim ESRD Action Code is equal to 'C' or 'U', bypass this edit.</p>	<p>Deactivate</p> <p>DMAC can determine if supplies are not billed at the Beneficiary's home.</p>	<p>VMS contains an online table, APPL/4/M2, that controls which places of service are appropriate for each procedure code; however, the DME MACs currently have additional places of service, other than these listed, that are valid for DME procedure codes.</p> <p><u>Edit:</u> 3013 MPR – PLACE: Place is not found on the MPR for this procedure. Use APPL/4 to verify the data.</p>
<p><u>C029</u> Invalid Patient Residence.</p> <p>Type of Record: CMN</p> <p>When the CMN patient residence is not equal to '01' Pharmacy '04' Homeless Shelter '09' Prison/Correctional Facility '12' Home</p>	<p>Deactivate</p> <p>DMAC can determine if HUCM is submitted and the Place of Service is not the Beneficiary's home.</p>	<p>VMS does not currently contain editing within CMNs that restricts place of service to these places of service ("home"). VMS does, however, have an edit that processes based on the values on the VMAP/4C POSTABLE. CMN Edit 1009-PLACE SERVICE INV prompts when the POS on the CMN does not match one of the values on the POSTABLE</p>

<p>'13' Assisted Living Facility '14' Group Home '31' Skilled Nursing Facility '32' Nursing Facility '33' Custodial Care Facility '34' Hospice '54' Intermediate Care Facility/Mentally Retarded '55' Substance Abuse Treatment Facility '56' Psychiatric Treatment Facility, or '61' Comprehensive Inpatient Rehabilitation Facility and the CMN DMEPOS category is not equal to '7', and the CMN patient residence is not equal to '21', set the 'C029' error code.</p> <p>When the CMN transaction type is equal to '3', bypass this edit.</p>		<p>(which includes all valid places of service).</p> <p>In addition, the CWF logic for this edit is actually executed within VMS, as is the logic for all other CWF CMN edits. This editing is accomplished by the inclusion of CWF module CABEDCMN in the VMS system. As long as the CWF module exists within VMS, the edit will continue to prompt based on the existing criteria; however, it can manually be set to ignore without system changes.</p>
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