CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 13243	**Date: May 22, 2025**
	Change Request 14070

SUBJECT: Technical Revisions Only to the Claims Processing Manual (CPM), Publication (Pub) 100-04, Chapter 18 and Chapter 32

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to announce technical changes that were made to the Claims Processing Manual (CPM), Publication 100-04, Chapters 18 and 32.

EFFECTIVE DATE: June 23, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 23, 2025

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	18/160/160.2.1/Correct Place of Service (POS) Codes for IBT for CVD on Professional Claims
R	18/170/170.5/Specialty Codes and Place of Service (POS)
R	18/180/180.3 Professional Billing Requirements
R	18/190/190.3/Place of Service (POS)
R	32/140/140.2.2.1/Correct Place of Service (POS) Code for CR and ICR Services on Professional Claims

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: 13243	Date: May 22, 2025	Change Request: 14070

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to announce technical changes that were made to the Claims Processing Manual (CPM), Publication 100-04, Chapters 18 and 32.

II. GENERAL INFORMATION

A. Background: CMS has identified a technical change in section 140.2.2.1 Correct Place of Service (POS) Code for Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services on Professional Claims of the Claims Processing Manual (CPM), Publication (Pub) 100-04, Chapter 32, Billing Requirements for Special Services, section 140.2.2.1 and Chapter 18, Preventive and Screening Services, sections 160.2.1, 170.5, 180.3 and 190.3.

B. Policy: For purposes of clarity, consistency, and accuracy, CMS is making technical revisions to the CPM Chapters 18 and 32 to add Place of Service (POS) 19 for (CR) and (ICR) Services on Professional claims. There is nothing included in this update that revises current coverage policy and that has not already been conveyed to the public via previous change requests.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
14070.1	Contractors shall be aware of the technical revisions to the CPM Publication 100-04, Chapter 32, Billing Requirements for Special Services, section 140.2.2.1 and Chapter 18, Preventive and Screening Services, sections 160.2.1, 170.5, 180.3 and 190. 3. No policy is affected by this revision.		X							

IV. PROVIDER EDUCATION

CR as Provider Education: MACs shall use the content in the CR to develop relevant education material. Provide a link to the entire instruction in the education content. You can also supplement with local

information that would help your provider community bill and administer the Medicare Program correctly. You don't need to separately track and report on this education.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. 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

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 18 - Preventive and Screening Services

Table of Contents
(Rev.13243; Issued: 05-22-25)

160.2.1 - Correct Place of Service (POS) Codes for IBT for CVD on Professional Claims
(Rev. 13243; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

A/B MACs (B) shall pay for IBT CVD, G0446 only when services are provided at the following POS:

11- Physician's Office
19- Off Campus- Outpatient Hospital
22- *On Campus* - Outpatient Hospital
49- Independent Clinic
72- Rural Health Clinic

Claims not submitted with one of the POS codes above will be denied.

The following messages shall be used when A/B MACs (B) deny professional claims for incorrect POS:

Claim Adjustment Reason Code (CARC) 58: "Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service." NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Remittance Advice Remark Code (RARC) N428: "Not covered when performed in this place of service."

Medicare Summary Notice (MSN) 21.25: "This service was denied because Medicare only covers this service in certain settings."

Spanish Version: El servicio fue denegado porque Medicare solamente lo cubre en ciertas situaciones."

Group Code PR (Patient Responsibility) assigning financial liability to the beneficiary, if a claim is received with a GA modifier indicating a signed ABN is on file.

Group Code CO (Contractual Obligation) assigning financial liability to the provider, if a claim is received with a GZ modifier indicating no signed ABN is on file.

170.5 - Specialty Codes and Place of Service (POS)

(Rev. 13243; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

Medicare provides coverage for screening for chlamydia, gonorrhea, syphilis, and/or hepatitis B and HIBC to prevent STIs only when ordered by a primary care practitioner (physician or non-physician) with any of the following specialty codes:

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

Medicare provides coverage for HIBC to prevent STIs only when provided by a primary care practitioner (physician or non-physician) with any of the specialty codes identified above.

Medicare provides coverage for HIBC to prevent STIs only when the POS billed is 11, *19,* 22, 49, or 71.

180.3 - Professional Billing Requirements

(Rev. 13243; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

For claims with dates of service on and after October 14, 2011, CMS will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and behavioral counseling for alcohol misuse, 15 minutes, G0443, 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
42 - Certified Nurse-Midwife
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.

For claims with dates of service on and after October 14, 2011, CMS will allow coverage for annual alcohol misuse screening, 15 minutes, G0442, and behavioral counseling for alcohol

misuse, 15 minutes, G0443, 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 or

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

The alcohol screening/counseling services are payable with another encounter/visit on the same day. This does not apply for IPPE.

190.3 - Place of Service (POS)

(Rev. 13243; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

A/B MACs (B) shall pay for annual depression screening claims, G0444, only when services are provided at the following places of service (POS):

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

Medicare Claims Processing Manual
Chapter 32 – Billing Requirements for Special Services

Table of Contents
(Rev.13243; Issued: 05-22-25)

140.2.2.1 – Correct Place of Service (POS) Code for CR and ICR Services on Professional Claims
(Rev. 13243; Issued: 05-22-25; Effective: 06-23-25; Implementation: 06-23-25)

Effective for claims with dates of service on and after January 1, 2010, place of service (POS) code 11 shall be used for CR and ICR services provided in a physician's office and *POS 19 and* POS 22 shall be used for services provided in a hospital outpatient setting. All other POS codes shall be denied. Contractors shall adjust their prepayment procedure edits as appropriate.

The following messages shall be used when contractors deny CR and ICR claims for POS:

Claim Adjustment Reason Code (CARC) 171 – Payment is denied when performed/billed by this type of provider in this type of facility.

NOTE: Refer to the 832 Healthcare Policy Identification Segment (loop 2110 Service payment Information REF), if present.

Remittance Advice Remark Code (RARC) N428 - Service/procedure not covered when performed in this place of service.

Medicare Summary Notice (MSN) 21.25 - This service was denied because Medicare only covers this service in certain settings.

Group Code PR (Patient Responsibility) - Where a claim is received with the GA modifier indicating that a signed ABN is on file.

Group Code CO (Contractor Responsibility) – Where a claim is received with the GZ modifier indicating that no signed ABN is on file.