CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3490	**Date: April 1, 2016**
	Change Request 9344

Transmittal 3484, dated March 25, 2016, is being rescinded and replaced by Transmittal 3490, dated March 31, 2016, to include the most current version of Pub 100-04, Chapter 26, Section 10.6, to also include the additional updates required to resolve the conflict with Pub 100-04, Chapter 1, Section 80.3.1 and to remove the responsibility of MAC A and MAC HHH within the Business Requirements. All other information remains the same.

SUBJECT: Medicare Internet Only Manual Publication 100-04 Chapter 26 - Completing and Processing Form CMS-1500 Data Set

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to modify the current version of Pub. 100-04, Chapter 26 - Completing and Processing Form CMS-1500 Data Set, Section 10.6 – Carrier Instructions for Place of Service (POS) to modify existing information. Additional clarification of instruction has been added to this chapter.

EFFECTIVE DATE: April 25, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 25, 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	26/10.6 - Carrier 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: 3490	Date: April 1, 2016	Change Request: 9344

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SUBJECT: Medicare Internet Only Manual Publication 100-04 Chapter 26 - Completing and Processing Form CMS-1500 Data Set

EFFECTIVE DATE: April 25, 2016
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IMPLEMENTATION DATE: April 25, 2016

I. GENERAL INFORMATION

A. Background: Pub. 100-04, Chapter 26 - Completing and Processing Form CMS-1500 Data Set, Section 10.6 – Carrier Instructions for Place of Service (POS) Codes contains non-compliant Remittance Advice (RA) messaging specifically Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC). The purpose of this CR is to ensure that RA Messaging is compliant with the Operating Rules.

B. Policy: No new policy.

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	
9344.1	Contractor shall follow instruction outlined in the attached Pub. 100-04, Chapter 26 - Completing and Processing Form CMS – 1500 Data Set regarding the Remittance Advice (RA) messaging in Section 10. 6 – Carrier Instructions for Place of Service (POS) Codes.		X		X					CEDI

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"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): Charlene Parks, 410-786-8684 or Charlene.Parks@cms.hhs.gov , Matthew Klischer, 410-786-7488 or Matthew.Klischer@cms.hhs.gov

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

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

(Rev.3440, Issued: 04-01-16, Effective: 04-25-16, Implementation: 04-25-16)

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 *Group Code CO, Claim Adjustment Remark Code (CARC) 16, and Remittance Advice Remark Code (RARC) 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 services as unprocessable.

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 services as unprocessable 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 services as unprocessable.