CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 121 | Date: MARCH 19, 2004

CHANGE REQUEST 3087

I. SUMMARY OF CHANGES:
This transmittal manualizes Program Memorandum Transmittal B-03-040, CR 2730, dated May 16, 2003, regarding the Place of Service (POS) code set and revises the wording of the Group Home Code, 14, effective April 1, 2004. The revised wording of the code will not result in systems changes.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 1, 2004
***IMPLEMENTATION DATE: April 1, 2004**

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.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	26/10.4/Items 14-33 – Provider of Service or Supplier Information
R	26/10.5/Place of Service Codes (POS) and Definitions

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 121	Date: March 19, 2004	Change Request 3087

SUBJECT: Manualization of Place of Service (POS) Code Set Program Memorandum; Revision to Group Home Code Description

I. GENERAL INFORMATION

A. Background: These business requirements were previously published in Change Request (CR) 2730, Transmittal B-03-040, published May 16, 2003. References to previously published CR 2259 Transmittal B-02-055, published August 7, 2002 were replaced with the applicable content from CR 2259. Where necessary, references to Chapter 26, Section 10.4, are also included. While previously published and implemented, the business requirements of CR 2730 are presented in this attachment to ensure their inclusion in the appropriate section of the Internet Only Manual. In addition, these business requirements reiterate the necessity to inform providers of updates to the POS code set; the revision of description for the Group Home code, 14, is one such update.

B. Policy:

- 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.

C. Provider Education: A provider education article related to this instruction will be available at http://www.cms.hhs.gov/medlearn/matters shortly after the CR is released. It will reflect only the change to the description of "14 Group Home." Because you have been previously informed through earlier CRs of all of the other information, and instructed to educate your providers regarding this information, the other content of this CR will not appear in the MedLearn article and is presented here only to manualize it.

You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3087.1	Shared systems maintainers (SSMs) and carriers shall recognize and accept as valid all POS codes from the National POS code set where these implementation guide edits are currently performed.	SSMs, and carriers, as applicable
3087.2	CWF shall recognize all POS codes from the National POS code set where it has edits in place to validate these codes claims.	CWF
3087.3	Where National policy and instructions exist regarding these codes, CWF, SSMs, and carriers shall follow such policy and instructions for using these codes for both paper and electronic claims.	CWF, SSMs, carriers
3087.4	Carriers shall apply either the facility or nonfacility rates to payment for services rendered in these settings according to National Medicare instructions they have received for both paper and electronic claims.	Carriers
3087.5	Where there are no National Medicare instructions or policy regarding the services payable in a given setting, carriers shall work with their medical directors to develop local policy to that effect, taking into consideration related applicable National policy for both paper and electronic claims. The local policy must result in payment appropriate for the setting and may include a crosswalk to another setting at the carrier's discretion.	Carriers
3087.6	Carriers shall have the option of continuing to use the crosswalks previously mandated or developing their own local policies for codes to which the crosswalks applied in terms of which services are payable in a given setting as long as there is no other National Medicare policy precluding the development of local policy for a given setting, for both paper and electronic claims. Carriers shall work with their medical directors regarding local policy development and decisions. The local policy must result in payment appropriate for the setting and may include a crosswalk to another setting at the carrier's discretion.	Carriers

3087.7	Carriers shall follow their current jursidiction procedures to process claims in these settings.	Carriers
3087.8	After the initial validation and acceptance of the POS codes as valid in terms of HIPAA compliance, carriers shall follow their return as unprocessable instructions for IHS codes 05 and 06 as well as Tribal 638 codes 07 and 08 for electronic claims; they shall follow their "return as unprocessable" instructions for paper claims containing these codes. Carriers using remark codes when returning a claim as unprocessable shall use "M77 Missing/incomplete/invalid place of service" for such claims.	Carriers
3087.9	Carriers shall adjudicate claims for durable medical equipment furnished in Homeless Shelters (code 04) so that the services are covered when other coverage conditions are met; i.e., not denied based on the setting, for both paper and electronic claims. Working with Carrier Medical Directors, carriers shall ensure that payment is appropriate for the services provided in this setting, taking into account that multiple patients are typically seen in this setting.	Carriers
3087.10	Carriers shall inform their providers of the latest carrier processing requirements and updates to the POS code set as noted in Section I.C. above. Carriers were previously instructed to inform their providers of earlier changes to the POS code set via the applicable program memoranda via their next regularly scheduled bulletins, and through a posting on their Web site and notification through electronic bulletin boards and listservs within 4 weeks of receiving those instructions. Refer to Chapter 26, Section 10.4 (provide hyperlink) for current updates to the POS code set.	Carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
3087.1	POS code validation edits shall continue to occur at the points in the process where they currently reside, either at the carrier-level, standard system level, or both. (A primary purpose of POS code set update instructions issued to date has been and continues to be to indicate the new codes to be validated, but not the manner in which they are to be validated. Issues regarding overall HIPAA compliance and contractor edits for this compliance are addressed in separate instructions.

3087.2, 3087.3, 3087.5	CWF shall include the valid codes from the National POS code set in its edit for valid POS for type of service "W" (physical therapy; doing so will permit the carriers to develop their own policies as appropriate and needed for these services in the new settings without an automatic rejection by CWF.) The new codes to be included and implemented, effective October 1, 2003: 03, 04, 05, 06, 07, 08, 13, 14, 15, 20, 49, 57
3087.11	If carriers elect to use a crosswalk approach to implementing National and/or local policy, they may implement it at the carrier level, the standard systems level, or a combination of both, depending on design and systems considerations and as long as the policy developed Nationally or locally is unaffected by the crosswalk. A crosswalk approach may be either a literal mapping of one POS code to another or it can be a "treat as" approach as long as National Claims History, all reports, and outbound information, including coordination of benefits, reflect the original POS code on the incoming claim. Any selected crosswalk shall not result in altering the content of the incoming claim (a literal mapping of one POS code to another is acceptable as a means of processing the claim internally within CMS systems as long as the switch of codes is temporary, remains internal to CMS processing, and is transparent to the ultimate results of processing the claim; all outbound information and other information regarding the claim shall show the original POS code supplied by the provider).

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
N/A	

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2003 (April 1, 2004 for new group home code description) **Implementation Date: October 1, 2003 (Implementation Date for new group home code description: April 1, 2004)** **Note: The October 1, 2003, effective and implementation dates here reflect those of the previously issued instructions which are being manualized.** **Pre-Implementation Contact(s): Claudette Sikora CMM/PBG/DPCP 410-786-5618** **Post-Implementation Contact(s): Regional Offices**	**These instructions shall be implemented within your current operating budget.**

10.4 - Items 14-33 - Provider of Service or Supplier Information
(Rev. 121, 03-19-04)

B3-3005.4, B3-4020.2, B4-2010.2; B-03-045; AB-03-091; B-00-15; B-98-28; TR-1712; TR-1718; TR-1819

Reminder: For date fields other than date of birth, all fields must 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.

Item 15 - Leave blank. Not required by Medicare.

Item 16 - If the patient is employed and is unable to work in 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.

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 who orders nonphysician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

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 must include the ordering/referring physician's name and Unique Physician Identification Number (UPIN). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services; and
- Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician's name and UPIN (the NPI will be used when implemented). For example, a surgeon must complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN (the NPI will be used when implemented) must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services must obtain a UPIN (the NPI will be used when implemented) even though they may never bill Medicare directly. A physician who has not been assigned a UPIN must contact the Medicare carrier.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN (the NPI will be used when implemented) of the physician supervising the limited licensed practitioner must appear in items 17 and 17a.
When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.
Enter the original ordering/referring physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the first claim form.
Enter the ordering (performing) physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).
Surrogate UPINs - If the ordering/referring physician has not been assigned a UPIN (the NPI will be used when implemented), one of the surrogate UPINs listed below must be used in item 17a. The surrogate UPIN used depends on the circumstances and is used only until the physician is assigned a UPIN. Enter the physician's name in item 17 and the surrogate UPIN in item 17a. All surrogate UPINs, with the exception of retired physicians (RET00000), are temporary and may be used only until a UPIN is assigned. The contractor must monitor claims with surrogate UPINs.
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.

Item 17a - Enter the CMS assigned UPIN (the NPI will be used when implemented) of the referring/ordering physician listed in item 17.
When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 must be used for each ordering/referring physician.

Contractors use the following surrogate UPINs for physicians who have not been assigned individual UPINs. Claims received with surrogate numbers will be tracked and possibly audited.

- Residents who are issued a UPIN in conjunction with activities outside of their residency status must use that UPIN. For interns and residents without UPINs, use the 8-character surrogate UPIN RES00000;
- Retired physicians who were not issued a UPIN may use the surrogate RET00000;
- Physicians serving in the Department of Veterans Affairs or the U.S. Armed Services may use VAD00000;
- Physicians serving in the Public Health or Indian Health Services may use PHS00000;
- The law extends coverage and direct payment in non-Metropolitan Statistical Areas to practitioners who are State licensed to order medical services or refer patients to Medicare providers without the approval or collaboration of a supervising physician. Billers use the surrogate UPIN "UPIN0000" on claims involving services ordered/referred by nurse practitioners, clinical nurse specialists, or any nonphysician practitioner who is State licensed to order clinical diagnostic tests; and
- When the ordering/referring physician has not been assigned a UPIN and does not meet the criteria for using one of the surrogate UPINs, the biller may use the surrogate UPIN "OTH00000" until an individual UPIN is assigned.
  NOTE: This field is required 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 PIN (NPI when it becomes effective) of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file (See Medicare Benefits Policy Manual, Chapter 15).

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 contractor is certifying that all the relevant information requirements (including level of subluxation) of the Medicare Benefits Policy Manual, Chapter 15, are on file, along with the appropriate x-ray and all are available for carrier 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 must 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 the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Services," and the Claims Processing Manual, Chapter 16, "Laboratory Services," and the 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 participating provider. In this case, no payment may be made on the claim.
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 the PIN (or NPI when effective) of the physician who is performing a purchased interpretation of a diagnostic test (see the Medicare Claims Processing Manual, Chapter1, "General Billing Requirements," for additional information). Report the interpreting physician's PIN proceeded by a "PI" indicator (i.e., PI999999).
NOTE: Item 19 can contain up to three conditions per claim. Additional conditions must be reported on a separate Form CMS-1500.
Item 20 - Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase 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 purchased tests are included on the claim." When "yes" is annotated, item 32 must be completed. When billing for multiple purchased diagnostic tests, each test on the Form CMS-1500, each test must be submitted on a separate claim form. Multiple purchased 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 purchase price limitations.
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) must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary

condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.
All narrative diagnoses for nonphysician specialties must be submitted on an attachment.
Item 22 - Leave blank. Not required by Medicare.
Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring PRO prior approval.
Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial.
For physicians performing care plan oversight services, enter the 6-digit Medicare provider number 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.
When a physician provides services to a beneficiary residing in a SNF and the services were rendered to a SNF beneficiary outside of the SNF, the physician should enter the Medicare facility provider number of the SNF in item 23.
A substituting physician under a reciprocal billing or locum tenens arrangement (mandated by statute §1842(b)(6)(D) of the Act) may be accommodated using item 23. The billing "absentee" physician's Provider Identification Number (PIN) must continue to be reported in item 33 under solo practice arrangements and in item 24k under group practice arrangements.
NOTE: Item 23 can contain only one condition. Any additional conditions must be reported on a separate Form CMS-1500.
Item 24a - Enter an 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 one 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 location, using a place of service code, for each item used or service performed. This is a required field.
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.
Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a 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 must be submitted with the claim. This is a required field.
Return as unprocessable if an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24d, but an accompanying narrative is not present in Item 19 or on an attachment.
Item 24e - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary

reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the contractor must 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.

Suppliers must furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems. Rounding of oxygen contents is as follows:

For stationary gas system rentals, suppliers must indicate oxygen contents in unit multiples of 50 cubic feet in item 24g, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" indicating the nearest 50 cubic foot increment is entered in item 24g.

For stationary liquid systems, units of contents must be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10-pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, the unit entry "06" is entered in item 24g.

For units of portable contents only (i.e., no stationary gas or liquid system used), round to the nearest five feet or one liquid pound, respectively.

NOTE: This field should contain at least one day or unit. The carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

Item 24h - Leave blank. Not required by Medicare.

Item 24I - Leave blank. Not required by Medicare.

Item 24j - Leave blank. Not required by Medicare.

Item 24k - Enter the PIN (the NPI will be used when implemented) of the performing provider of service/supplier if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, show the individual PIN in the corresponding line item.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number. The participating provider of service or supplier Federal Tax ID number is required for a mandated Medigap transfer.

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 block 9 and

Medigap payment authorization is given in item 13, the provider of service or supplier must also be a Medicare participating provider of service or supplier and must 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; and
- Drugs and biologicals.

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.
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 - 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, 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, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms must be submitted.
Providers of service (namely physicians) must identify the supplier's name, address, ZIP code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.
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 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 carrier 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 address, or PIN of the location where the order was accepted must be entered (DMERC only).

This field is required. When more than one supplier is used, a separate Form CMS-1500 should 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 a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered must be entered if other than home.
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, and the PIN, must be indicated.
If a physician performs a service (s) in a hospital (Place of Service Codes = 21, 22, 23), the physician must enter the Medicare provider number, in addition to name and address. When entering the Medicare provider number, precede each number with HSP. Only one provider number per claim may be billed.
Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.
Enter the UPIN, for the performing provider of service/supplier who is **not** a member of a group practice. This includes the PIN of a billing "absentee" physician is a solo practice.
Enter the group PIN for the performing provider of service/supplier who is a member of a group practice.
Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this field.

10.5 - Place of Service Codes (POS) and Definitions

(Rev. 121, 03-19-04)

- *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) as well as Indian Health Service (codes 05, 06) and Tribal 638 (codes 07, 08) settings, described below. Where there is no National policy for a given POS code, carriers may work with their carrier 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, carriers must pay for the services at either the facility or the nonfacility rate as designated below. In addition, carriers, 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, carriers 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 carrier develops local policy for these settings, but later receives specific National instructions for these codes, the carriers shall defer to and comply with the newer instructions. (**Note**: While, effective January 1, 2003, codes 03 School, 04 Homeless Shelter, and 20 Urgent Care became part of the National POS code set and were to be crosswalked to 11 Office, this mandate to crosswalk has since been lifted as indicated above).*

- *The National POS Code Set and Instructions for Using It*

  The following is the current National POS code set, with facility and non-facility designations noted for Medicare payment for services on the Physician Fee Schedule. With the exception of a revised definition for Group Home (14), which will be effective on April 1, 2004, this is the National POS code set code that was in effect as of October 1, 2003. Note that codes 03, 04, 05, 06, 07, 08, 15, and 20 became part of the National POS code set effective January 1, 2003, and codes 13, 14, 49, and 57 became part of the National code set effective October 1, 2003.

POS Code/Name Description *= New or revised code, or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
01-02 Unassigned	--
03/School A facility whose primary purpose is education.	NF
04/Homeless Shelter A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters). (See note below.)	NF
05 Indian Health Service Free-standing Facility A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization . (See instructions below)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
06 Indian Health Service Provider-based Facility A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients. (See instructions below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
07 Tribal 638 Free-Standing Facility A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization . (See instructions below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
08 Tribal 638 Provider-Based Facility A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (See instructions below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
09-10/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 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

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
*14/Group Home (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 A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.	NF
16-19/Unassigned	--
20/Urgent Care Facility Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	NF
21/Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	F
22/Outpatient Hospital A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	F
23/Emergency Room-Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	F

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
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 (**Note:** pay at the nonfacility rate for payable procedures not on the ASC list)
25/Birthing Center A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.	NF
26/Military Treatment Facility A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).	F
27-30/Unassigned	--
31/Skilled Nursing Facility A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.	F
32/Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	NF

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=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 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

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
51/Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	F
52/Psychiatric Facility-Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	F
53/Community Mental Health Center A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.	F
54/Intermediate Care Facility/Mentally Retarded 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

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=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 A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	NF
58-59/Unassigned	--
60/Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	NF
61/Comprehensive Inpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	F
62/Comprehensive Outpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	NF
63-64/Unassigned	--

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
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 directionof a physician.	NF
72/Rural Health Clinic A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	NF
73-80/Unassigned	
81/Independent Laboratory A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	NF
82-98/Unassigned	
99/Other Place of Service Other place of service not identified above.	NF

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

  Note that for the purposes of receiving durable medical equipment (DME), a homeless shelter is considered the beneficiary's home. Because DME is payable in the beneficiary's home, the crosswalk for Homeless Shelter (code 04) to Office (code 11) that was *mandated effective January 1, 2003*, may need to be adjusted or local policy developed so that HCPCS codes for DME are covered when other conditions are met and the beneficiary is in a homeless shelter. If desired, carriers are permitted to work with their carrier 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 carrier 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.

- ***Paper Claims***

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