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Medicare Claims Processing Manual

Chapter 26 - Completing and Processing Form CMS-1500 Data Set

Table of Contents
(Rev. 3255, 05-08-15)

10 - Health Insurance Claim Form CMS-1500

(Rev. 3083, Issued: 10-02-14, Effective: CMS-1500: 01-06-14, ICD-10 – Upon Implementation of ICD-10, Implementation: CMS-1500: 01-06-14, ICD-10 – Upon Implementation of ICD-10)

The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Providers meeting an ASCA exception may send their claims to Medicare on a paper claim form. (For more information regarding ASCA exceptions, refer to Chapter 24.)

Providers sending professional and supplier claims to Medicare on paper must use Form CMS-1500 in a valid version. This form is maintained by the National Uniform Claim Committee (NUCC), an industry organization in which CMS participates. Any new version of the form must be approved by the White House Office of Management and Budget (OMB) before it can be used for submitting Medicare claims. When the NUCC changes the form, CMS coordinates its review, any changes, and approval with the OMB.

The NUCC has recently changed the Form CMS-1500, and the revised form received OMB approval on June 10, 2013. The revised form is version 02/12, OMB control number 0938-1197.

The revised form will replace the previous version of the form 08/05, OMB control number 0938-0999.

Throughout this chapter, the terms, “Form CMS-1500,” “Form 1500,” and “CMS-1500 claim form” may be used to describe this form depending upon the context and version. The term, “CMS-1500 claim form” refers to the form generically, independent of a given version.

Medicare will conduct a dual-use period during which providers can send Medicare claims on either the old or the revised forms. When the dual-use period is over, Medicare will accept paper claims on only the revised Form 1500, version 02/12.

For the implementation and dual-use dates, contractors shall consult the appropriate implementation change requests for the revised Form 1500. Providers and other interested parties may obtain the implementation dates on the CMS web site @ www.cms.gov.

Reminder: Regardless of the paper claim form version in effect: **Providers cannot submit ICD-10-CM codes for claims with dates of service prior to implementation of ICD-10.**

Medicare A/B MACS (B), DME MACS, physicians, and suppliers are responsible for purchasing their own CMS-1500 claim forms. Forms can be obtained from printers or printed in-house as long as they follow the specifications developed by the NUCC. Photocopies of the CMS-1500 claim form are NOT acceptable. Medicare will accept any

type (i.e., single sheet, snap-out, continuous feed, etc.) of the CMS-1500 claim form for processing. To purchase forms from the U.S. Government Printing Office, call (202) 512-1800.

The following instructions are required for a Medicare claim. They apply to both the 08/05 and 02/12 versions of the form except where noted. A/B MACs (B) and DME MACs should provide information on completing the CMS-1500 claim form to all physicians and suppliers in their area at least once a year.

These instructions represent the minimum requirements for using this form to submit a Medicare claim. However, depending on a given Medicare policy, there may be other data that should also be included on the CMS-1500 claim form; if so, these additional requirements are addressed in the instructions you received for such policies (e.g., other chapters of this manual).

Providers may use these instructions to complete this form. The CMS-1500 claim form has space for physicians and suppliers to provide information on other health insurance. This information can be used by A/B MACs (B) to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment, or whether there is another insurer to which Medicare can forward billing and payment data following adjudication if the provider is a physician or supplier that participates in Medicare. (See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3, and chapter 28 of this manual).

Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for <u>all</u> these fields. For instance, a provider of service or supplier will <u>not</u> be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

Legend	**Description**
MM	Month (e.g., December = 12)
DD	Day (e.g., Dec15 = 15)
YY	2 position Year (e.g., 1998 = 98)
CCYY	4 position Year (e.g., 1998 = 1998)
(MM | DD | YY) or (MM | DD | CCYY)	A space must be reported between month, day, and year (e.g., 12 | 15 | 98 or 12 | 15 | 1998). This space is delineated by a dotted vertical line on the Form CMS-1500)

Legend	Description
(MMDDYY) or (MMDDCCYY)	No space must be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

10.1 – Claims That are Incomplete or Contain Invalid Information
(Rev. 145, 04-23-04)

If a claim is submitted with incomplete or invalid information, it may be returned to the submitter as unprocessable. See Chapter 1 for definitions and instructions concerning the handling of incomplete or invalid claims.

10.2 - Items 1-11 - Patient and Insured Information
(Rev. 3083, Issued: 10-02-14, Effective: CMS-1500: 01-06-14, ICD-10 – Upon Implementation of ICD-10, Implementation: CMS-1500: 01-06-14, ICD-10 – Upon Implementation of ICD-10)

Item 1 - Shows the type of health insurance coverage applicable to this claim by the appropriately checked box; check the Medicare box.

Item 1a - Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. This is a required field.

Item 2 - Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. This is a required field.

Item 3 - Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

Item 4 - If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5 - Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6 - Check the appropriate box for patient's relationship to insured when item 4 is completed.

Item 7 - Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed.

Item 8 – Form version 08/05: Check the appropriate box for the patient's marital status and whether employed or a student.

Form version 02/12: Leave blank.

Item 9 - Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. **This field may be used in the future for supplemental insurance plans.**

NOTE: Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the *b*eneficiary wishes to assign his/her benefits under a MEDIGAP policy to the participating physician or supplier.

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. (See chapter 28.)

Medigap - Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the A/B MAC (B) or DME MAC to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item 9a - Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

NOTE: Item 9d must be completed, even when the provider enters a policy and/or group number in item 9a.

Item 9b – Form version 08/05: Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.
Form version 02/12: Leave blank.

Item 9c - Leave blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card. For example:

1257 Anywhere Street
Baltimore, MD 21204

is shown as "1257 Anywhere St. MD 21204."

Item 9d - Enter the Coordination of Benefits Agreement (COBA) Medigap-based Identifier (ID). Refer to chapter 28, section 70.6.4, of this manual for more information.

Items 10a through 10c - Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the State postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Item 10d - Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

Item 11 - THIS ITEM MUST BE COMPLETED, IT IS A REQUIRED FIELD. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11.

If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

If a lab has collected previously and retained Medicare Secondary Payer (MSP) information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the

lab will enter the word “None” in Block 11, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to Medicare - Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
    - Working Aged;
    - Disability (Large Group Health Plan); and
    - End Stage Renal Disease;
- No Fault and/or Other Liability; and
- Work-Related Illness/Injury:
    - Workers' Compensation;
    - Black Lung; and
    - Veterans Benefits.

NOTE: For a paper claim to be considered for MSP benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. (See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3.)

10.3 - Items 11a - 13 - Patient and Insured Information

(Rev. 3083, Issued: 10-02-14, Effective: CMS-1500: 01-06-14, ICD-10 – Upon Implementation of ICD-10, Implementation: CMS-1500: 01-06-14, ICD-10 – Upon Implementation of ICD-10)

Item 11a Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

Item 11b – Form version 08/05: Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word, "RETIRED."

Form version 02/12: provide this information to the right of the vertical dotted line.

Item 11c - Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.

Item 11d - Leave blank. Not required by Medicare.

Item 12 - The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, "General Billing Requirements." If the patient is physically or mentally unable to sign, a representative specified in chapter 1, may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

NOTE: This can be "Signature on File" and/or a computer generated signature.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13 - The patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient's signature or a "signature on file" is not required in order for Medicare payment to be made directly to the physician or supplier.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream coordination of benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may affect supplemental payments to providers and/or their patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

NOTE: This can be "Signature on File" signature and/or a computer generated signature.

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

(Rev. 3255, Issued: 05-08-15, Effective: 10-01-15, Implementation: 10-05-15)

Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

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

Item 15 - Leave blank.

Item 16 - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. Similarly, if Medicare policy requires you to report a supervising physician, enter this information in item 17. When a claim involves multiple referring, ordering, or supervising physicians, use a separate CMS-1500 claim form for each ordering, referring, or supervising physician.

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

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

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

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

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician’s or non-physician practitioner’s service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;
- Effective for claims with dates of service on or after October 1, 2012, all claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner, require that the name and NPI of the certifying physician or nonphysician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b.

Item 17a – Leave blank.

Item 17b – Enter the NPI of the referring, ordering, or supervising physician or non-physician practitioner listed in item 17. All physicians and non-physician practitioners who order services or refer Medicare beneficiaries must report this data.

NOTE: Effective May 23, 2008, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Item 18 - Enter either an 8-digit (MM | DD | CCYY) or a 6-digit (MM | DD | YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19 - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the NPI of his/her attending physician when a physician providing routine foot care submits claims.

NOTE: Effective May 23, 2008, all provider identifiers submitted on the CMS-1500 claim form MUST be in the form of an NPI.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for A/B MAC (B) review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or a NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively, for the definition of

"homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits," when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter demonstration ID number “56” for all national Laboratory Affordable Care Act Section 113 Demonstration Claims.

Enter the NPI of the physician who is performing the technical or professional component of a diagnostic test that is subject to the anti-markup payment limitation. (See Pub. 100-04, chapter 1, section 30.2.9 for additional information.)

NOTE: Effective May 23, 2008, all provider identifiers submitted on the CMS-1500 claim form MUST be in the form of an NPI.

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Individuals and entities who bill A/B MACs (B) for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

Item 20 - Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation. Enter the acquisition price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the

service performed the diagnostic test. A "no" check indicates "no anti-markup tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple anti-markup tests, each test shall be submitted on a separate claim form CMS-1500. Multiple anti-markup tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to the anti-markup payment limitation.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use diagnosis codes to the highest level of specificity for the date of service. Enter the diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

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

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

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

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

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

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

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

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

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

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

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the NPI of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

For ambulance claims, enter the ZIP code of the loaded ambulance trip's point-of-pickup.

NOTE: Item 23 can contain only one condition. Any additional conditions should be reported on a separate CMS-1500 claim form.

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g., UN2 or F2999999).

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 day, and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the setting, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a patient who is a registered inpatient or an outpatient of a hospital, use the inpatient hospital POS code 21 or outpatient hospital POS code 22, respectively, as discussed in section 10.5 of this chapter.

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The CMS-1500 claim form has the capacity to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or a NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

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

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

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

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the provider shall reference only one of the diagnoses in item 21.

Item 24F- Enter the charge for each listed service.

Item 24G - Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies, medication dosages, or allergy

testing procedures). When multiple services are provided, enter the actual number provided.

For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

Beginning with dates of service on and after January 1, 2011, for ambulance mileage, enter the number of loaded miles traveled rounded up to the nearest tenth of a mile up to 100 miles. For mileage totaling 100 miles and greater, enter the number of covered miles rounded up to the nearest whole number miles. If the total mileage is less than 1 whole mile, enter a "0" before the decimal (e.g. 0.9). See Pub. 100-04, chapter 15, §20.2 for more information on loaded mileage and §30.1.2 for more information on reporting fractional mileage.

NOTE: This field should contain an appropriate numerical value. The A/B MAC (B) should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable, except on claims for ambulance mileage. For ambulance mileage claims, contractors shall automatically default "0.1" unit when total mileage units are missing in this field.

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

Item 24I - Enter the ID qualifier 1C in the shaded portion.

Item 24J - Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

NOTE: Effective May 23, 2008, the shaded portion of 24J is not to be reported.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

Item 26 - Enter the patient's account number assigned by the provider's of service or supplier's accounting system. This field is optional to assist the provider in patient identification. As a service, any account numbers entered here will be returned to the provider.

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall also be a Medicare participating provider of service or supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is

directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field; however, the claim can be processed if the following is true: if a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 – For services payable under the physician fee schedule and anesthesia services, enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, only one name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted. Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for anti-markup tests. When more than one supplier is used, a separate CMS-1500 claim form shall be used to bill for each supplier. (See Pub. 100-04, chapter 1, §10.1.1.2 for more information on payment jurisdiction for claims subject to the anti-markup limitation.)

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The A/B MAC (B) processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DME MAC only). This field is required. When more than one supplier is used, a separate CMS-1500 claim form shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a - If required by Medicare claims processing policy, enter the NPI of the service facility.

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

Item 32b - Effective May 23, 2008, Item 32b is not to be reported.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

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

10.5 - Place of Service Codes (POS) and Definitions

(Rev. 2679, Issued: 03-29-13, Effective: 04-01-13, Implementation: 04-01-13)

- HIPAA
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) became effective October 16, 2003, for all covered entities. Medicare is a covered entity under HIPAA.
  - The final rule, "Health Insurance Reform: Standards for Electronic Transactions," published in the **Federal Register**, August 17, 2000, adopts the standards to be used under HIPAA and names the implementation guides to be used for these standards. The ASC X12N 837 professional is the standard to be used for transmitting health care claims electronically, and its implementation guide requires the use of POS codes from the National POS code set, currently maintained by CMS.
  - As a covered entity, Medicare must use the POS codes from the National POS code set for processing its electronically submitted claims. Medicare must also recognize as valid POS codes from the POS code set when these codes appear on such a claim.

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

- National policy in the form of "Special Considerations" for Inpatient Hospital (POS code 21), Outpatient Hospital (POS code 22), Ambulatory Surgical Center (POS code 24) and Hospice (POS code 34) are included below, effective April 1, 2012. The national policy instructions for the Walk-In Retail Health Clinic (POS code 17) that were previously addressed in this section are located in a special considerations provision below.

- The National POS Code Set and Instructions for Using It

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

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

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

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
08 Tribal 638 Provider-Based Facility (January 1, 2003) A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (See instructions below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
09 Prison/Correctional Facility (July 1, 2006) A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (See instructions below.)	NF
10 Unassigned	
11 Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	NF
12 Home Location, other than a hospital or other facility, where the patient receives care in a private residence.	NF
13 Assisted Living Facility (October 1, 2003) Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.	NF
14 Group Home (Code effective, October 1, 2003; description revised, effective April 1, 2004) A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).	NF

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
15 Mobile Unit (January 1, 2003) A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.	NF
16 Temporary Lodging (April 1, 2008) A short-term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code.	NF
17 Walk-in Retail Health Clinic (No later than May 1, 2010) A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
18 Place of Employment/Worksite (No later than May 1, 2013) A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual.	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
20 Urgent Care Facility (January 1, 2003) Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	NF
21 Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	F
22 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

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
23 Emergency Room-Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	F
24 Ambulatory Surgical Center A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.	F
25 Birthing Center A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.	NF
27-30 Unassigned	--
31 Skilled Nursing Facility A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.	F
32 Nursing Facility A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.	NF
33 Custodial Care Facility A facility which provides room, board and other personal assistance services, generally on a longterm basis, and which does not include a medical component.	NF
34 Hospice A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	F
35-40 Unassigned	--

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
41 Ambulance—Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
42 Ambulance—Air or Water An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
43-48/Unassigned	--
49 Independent Clinic (October 1, 2003) A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.	NF
50 Federally Qualified Health Center A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.	NF
51 Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	F
52 Psychiatric Facility-Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a 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	F

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
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.	
54 Intermediate Care Facility/Mentally Retarded A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.	NF
55 Residential Substance Abuse Treatment Facility A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	NF
56 Psychiatric Residential Treatment Center A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	F
57 Non-residential Substance Abuse Treatment Facility (October 1, 2003) A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	NF
58-59 Unassigned	--
60 Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	NF
61 Comprehensive Inpatient Rehabilitation Facility	F

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

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

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

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

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

  Medicare does not currently use the POS codes designated for these settings. Follow the instructions you have received regarding how to process claims for services rendered in IHS and Tribal 638 settings. If you receive claims with these codes, you must initially accept them in terms of HIPAA compliance. However, follow your "return as unprocessable" procedures after this initial compliance check. Follow your "return as unprocessable" procedures when you receive paper claims with these codes. (Note that while these codes became part of the National POS code set effective January 1, 2003, Medicare contractors received instructions regarding how to process claims with these codes effective October 1, 2003, so that Medicare could be HIPAA compliant by October 16, 2003).

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

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

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

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

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

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

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

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

  When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF receiving inpatient skilled nursing care, POS 51, for a patient registered in a Psychiatric Inpatient Facility, and POS 61 for patients registered in a Comprehensive Inpatient Rehabilitation Facility.

- **Special Considerations for Outpatient Hospital Departments**

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

  NOTE: Physicians/practitioners who perform services in a hospital outpatient department shall use, at a minimum, POS code 22 (Outpatient Hospital). Code 22 (or other appropriate outpatient department POS code as described above) shall be used unless the physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42. C.F.R. 413.65. Physicians shall use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital. Use of POS code 11(office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.F.R 411.353 through 411.357.

- **Special Consideration for Ambulatory Surgical Centers (Code 24)**

  When a physician/practitioner furnishes services to a patient in a Medicare-participating ambulatory surgical center (ASC), the POS code 24 (ASC) shall be used.

  NOTE: Physicians/practitioners who perform services in an ASC shall use POS code 24 (ASC). Physicians/practitioners are not to use POS code 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC, which meets all other requirements for operating as a physician office at the same physical location as the ASC – including meeting the "distinct entity" criteria defined in the ASC State Operations Manual that precludes the ASC and an adjacent physician office from being open at the same

time -- and the physician service was actually performed in the office suite portion of the facility.

See Pub 100-07, Medicare State Operations Manual, Appendix L - Guidance for Surveyors: Ambulatory Surgical Centers for a complete set of applicable ASC definitions, basic requirements, and conditions of coverage. It is available at the following link:
http://www.cms.gov/manuals/Downloads/som107ap_l_ambulatory.pdf

- **Special Considerations for Hospice (Code 34)**

  When a physician/practitioner furnishes services to a patient under the hospice benefit, use the following guidelines to identify the appropriate POS.

  When a beneficiary is in an "inpatient" respite or general "inpatient" care stay, the POS code 34 (hospice) shall be used. When a beneficiary who has elected coverage under the Hospice benefit is receiving inpatient hospice care in a hospital, SNF**,** or hospice inpatient facility, POS code 34 (Hospice) shall be used to designate the POS on the claim.

  For services provided to a hospice beneficiary in an outpatient setting, such as the physician/nonphysician practitioner's office (POS 11); the beneficiary's home (POS 12), i.e., not operated by the hospice; or other outpatient setting (e.g., outpatient hospital (POS 22)), the patient's physician or nonphysician practitioner or hospice independent attending physician or nurse practitioner, shall assign the POS code that represents that setting, as appropriate.

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

- **Paper Claims**

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

10.6 - Carrier Instructions for Place of Service (POS) Codes
(Rev. 2679, Issued: 03-29-13, Effective: 04-01-13, Implementation: 04-01-13)

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 22) 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 Carriers 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) or outpatient hospital (POS code 22), respectively.

For hospital visits by physicians, presume, in the absence of evidence to the contrary, that visits billed for were made. However, review a sample of physician's records when there

are questionable patterns of utilization. Confirm these visits where the medical facts do not support the frequency of the physician's visits or in cases of beneficiary complaints.

If questioning whether the visit had been made, ascertain whether the physician's own entry is in the patient's record at the provider. Accept an entry where the nurses' notes indicate that the physician saw the patient on a given day. A statement by the beneficiary is also acceptable documentation if it was made close to the alleged date of the visit. Entries in the physician's records represent possible secondary evidence. However, these are of less value since they are self-serving statements. Exercise judgment regarding their authenticity. The policy requiring daily physician visits is not conclusive if, in the individual case, the facts did not support a finding that daily visits were made.

If a claim lacks a valid place of service (POS) code in item 24b, or contains an invalid POS in item 24b, return the claim as unprocessable to the provider or supplier, using RA remark code M77. Effective for claims received on or after April 1, 2004, only one POS may be submitted on the Form CMS-1500 for services paid under the MPFS and anesthesia services. If the place of service is missing and the carrier cannot infer the place of service from the procedure code billed (e.g., a procedure code for which the definition is not site specific or which can be performed in more than one setting), then return assigned services as unprocessable and develop for the place of service on nonassigned claims.

If place of service is inconsistent with procedure code billed, then edit for consistency or compatibility between the place of service and site-specific procedure codes. If the place of service is valid but inconsistent or incompatible with the procedure billed (e.g., the place of service is inpatient hospital and the procedure code billed is office visit), then return assigned services as unprocessable and develop nonassigned services since the carrier typically will not know whether the procedure code or the place of service is incorrect in such instances. If place of service is invalid, then edit for the validity of the place of service coding. If the place of service code is not valid (e.g., the number designation has not been assigned or defined by CMS), then return assigned services as unprocessable and develop for a valid place of service on nonassigned line items.

10.7 - Type of Service (TOS)

(Rev. 2814, Issued: 11-15-13, Effective: 01-01-14, Implementation: 01-06-14)

Medicare administrative contractors must assign the proper TOS using the annual HCPCS update from the CMS mainframe. Changes to this list are issued annually via a Recurring Update Notification. Some procedures may have more than one applicable TOS. For claims received on or after April 3, 1995, CWF produced alerts on codes with incorrect TOS designations. Effective July 3, 1995, CWF began rejecting codes with incorrect TOS designations.

The only exceptions to this annual update are:

- Surgical services billed for dates of service through December 31, 2007, containing the ASC facility service modifier SG must be reported as TOS F. Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare services. ASC providers should discontinue applying the SG modifier on ASC facility claims. The indicator 'F' does not appear in the TOS table because its use depends upon claims submitted with POS 24 (ASC Facility) from an ASC (specialty 49). This became effective for dates of service January 1, 2008 and after.

- Surgical services billed with an assistant-at-surgery modifier (80-82, AS,) must be reported with TOS 8. The 8 indicator does not appear on the TOS table because its use is dependent upon the use of the appropriate modifier. (See Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, "Physician/Nonphysician Practitioner," for instructions on when assistant-at-surgery is allowable.)

- TOS H appears in the list of descriptors. However, it does not appear in the table. In CWF, "H" is used only as an indicator for hospice. The contractor should not submit TOS H to CWF at this time.

- For outpatient services, when a transfusion medicine code appears on a claim that also contains a blood product, the service is paid under reasonable charge at 80%, coinsurance and deductible apply. When transfusion medicine codes are paid under the clinical laboratory fee schedule pay at 100%, coinsurance and deductible do not apply.

NOTE: For injection codes with more than one possible TOS designation, use the following guidelines when assigning the TOS:

When the choice is L or 1,

- Use TOS L when the drug is used related to ESRD; or

- Use TOS 1 when the drug is not related to ESRD and is administered in the office.

When the choice is G or 1:

- Use TOS G when the drug is an immunosuppressive drug; or

- Use TOS 1 when the drug is used for other than immunosuppression.

When the choice is P or 1,

- Use TOS P if the drug is administered through durable medical equipment (DME); or

- Use TOS 1 if the drug is administered in the office.

The place of service or diagnosis may be considered when determining the appropriate TOS. The descriptors for each of the TOS codes listed in the annual HCPCS update are:

Type of Service Indicators

0	Whole Blood
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Laboratory
6	Therapeutic Radiology
7	Anesthesia
8	Assistant at Surgery
9	Other Medical Items or Services
A	Used DME
B	High Risk Screening Mammography
C	Low Risk Screening Mammography
D	Ambulance
E	Enteral/Parenteral Nutrients/Supplies
F	Ambulatory Surgical Center (Facility Usage for Surgical Services)
G	Immunosuppressive Drugs
H	Hospice
J	Diabetic Shoes
K	Hearing Items and Services
L	ESRD Supplies
M	Monthly Capitation Payment for Dialysis
N	Kidney Donor
P	Lump Sum Purchase of DME, Prosthetics, Orthotics
Q	Vision Items or Services
R	Rental of DME
S	Surgical Dressings or Other Medical Supplies
T	Outpatient Mental Health Treatment Limitation
U	Occupational Therapy
V	Pneumococcal/Flu Vaccine
W	Physical Therapy

10.8 - Requirements for Specialty Codes

(Rev. 1725, Issued: 05-01-09, Effective: 07-01-09, Implementation: 07-06-09)

Medicare physician/non-physician practitioner specialty codes describe the specific/unique types of medicine that physicians and non-physician practitioners (and certain other suppliers) practice. Physicians self-designate their Medicare physician specialty on their Medicare enrollment application (CMS-855I) or on the Internet-based

Provider Enrollment, Chain and Ownership System. Non-physician practitioners are assigned a Medicare specialty code when they enroll based on their profession. Specialty codes are used by CMS for programmatic and claims processing purposes.

A. A physician specialty association will submit a specialty code request to the Director, Division of Practitioner Services, Center for Medicare Management, Centers for Medicare & Medicaid Services, Mail Stop C4-01-26, 7500 Security Blvd., Baltimore, MD 21244.

Medicare contractors shall not add any specialty codes to the list. They must send all requests for expansion of the specialty code list to the Director, Division of Practitioner Services, at the address above.

B. When considering a request for expanding the specialty code list for physician and non-physician practitioners, CMS will take into consideration the following:

- Whether the requested specialty has the authority to bill Medicare independently;
- The requester's stated reason or purpose for the code;
- Evidence that the practice pattern of the specialty is markedly different from that of the dominant parent specialty;
- Evidence of any specialized training and/or certification required;
- Whether the specialty treats a significant volume of the Medicare population;
- Whether the specialty is recognized by another organization, such as the American Board of Medical Specialties; and
- Whether the specialty has a corresponding Healthcare Provider Taxonomy Code.

Physicians may not have a specialty code of 70 (single or multi-specialty Clinic or Group Practice.) Contractors must contact physicians whose records indicate specialty code 70 and require the physicians to update their enrollment records by submitting a CMS-8551 with a specialty that is valid for a physician.

10.8.1 - Assigning Specialty Codes by Carriers and DMERCs

Physicians are allowed to choose a primary and a secondary specialty code. If the carrier and DMERC provider file can accommodate only one specialty code, the carrier or DMERC assigns the code that corresponds to the greater amount of allowed charges. For example, if the practice is 50 percent ophthalmology and 50 percent otolaryngology, the carrier/DMERC compares the total allowed charges for the previous year for ophthalmology and otolaryngology services. They assign the code that corresponds to the greater amount of the allowed charges.

10.8.2 - Physician Specialty Codes

(Rev. 3073, Issued: 9-23-14, Effective: 01-01-15, Implementation: 01-05-15)

Code	Physician Specialty
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Medicine
13	Neurology
14	Neurosurgery
16	Obstetrics/Gynecology
17	Hospice and Palliative Care
18	Ophthalmology
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
21	Cardiac Electrophysiology
22	Pathology
23	Sports Medicine
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Geriatric Psychiatry
28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
44	Infectious Disease
46	Endocrinology
48	Podiatry

Code	Physician Specialty
66	Rheumatology
70	Single or Multispecialty Clinic or Group Practice
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty
C0	Sleep Medicine
C3	Interventional Cardiology

10.8.3 - Nonphysician Practitioner, Supplier, and Provider Specialty Codes

(Rev. 3177, Issued: 01-30-15, Effective: 03-02-15, Implementation: 03-02-15)

The following list of 2-digit codes and narrative describe the kind of medicine non-physician practitioners or other healthcare providers/suppliers practice.

Code	Non-physician Practitioner/Supplier/Provider Specialty
15	Speech Language Pathologists
31	Intensive Cardiac Rehabilitation
32	Anesthesiologist Assistant
42	Certified Nurse Midwife (effective July 1, 1988)
43	Certified Registered Nurse Anesthetist (CRNA)
45	Mammography Screening Center
47	Independent Diagnostic Testing Facility (IDTF)
49	Ambulatory Surgical Center
50	Nurse Practitioner
51	Medical supply company with orthotic personnel certified by an accrediting organization
52	Medical supply company with prosthetic personnel certified by an accrediting organization

Code	Non-physician Practitioner/Supplier/Provider Specialty
53	Medical supply company with prosthetic/orthotic personnel certified by an accrediting organization
54	Medical supply company not included in 51, 52, or 53
55	Individual orthotic personnel certified by an accrediting organization
56	Individual prosthetic personnel certified by an accrediting organization
57	Individual prosthetic/orthotic personnel certified by an accrediting organization
58	Medical Supply Company with registered pharmacist
59	Ambulance Service Supplier, e.g., private ambulance companies, funeral homes
60	Public Health or Welfare Agencies (Federal, State, and local)
61	Voluntary Health or Charitable Agencies (e.g., National Cancer Society, National Heart Association, Catholic Charities)
62	Psychologist (Billing Independently)
63	Portable X-Ray Supplier (Billing Independently)
64	Audiologist (Billing Independently)
65	Physical Therapist in Private Practice
67	Occupational Therapist in Private Practice
68	Clinical Psychologist
69	Clinical Laboratory (Billing Independently)
71	Registered Dietician/Nutrition Professional
73	Mass Immunization Roster Billers (Mass Immunizers have to roster bill assigned claims and can only bill for immunizations)
74	Radiation Therapy Centers
75	Slide Preparation Facilities
80	Licensed Clinical Social Worker
87	All other suppliers, e.g., Drug Stores
88	Unknown Provider
89	Certified Clinical Nurse Specialist
95	Unknown Supplier
96	Optician
97	Physician Assistant
A0	Hospital
A1	Skilled Nursing Facility
A2	Intermediate Care Nursing Facility
A3	Nursing Facility, Other
A4	Home Health Agency
A5	Pharmacy
A6	Medical Supply Company with Respiratory Therapist
A7	Department Store
A8	Grocery Store
B1	Oxygen/Oxygen Related Equipment
B2	Pedorthic Personnel
B3	Medical Supply Company with Pedorthic Personnel

Code	Non-physician Practitioner/Supplier/Provider Specialty
B4	Rehabilitation Agency
B5	Ocularist
C1	Centralized Flu
C2	Indirect Payment Procedure
C4	Restricted Use

NOTE: Specialty Code Use for Service in an Independent Laboratory. For services performed in an independent laboratory, show the specialty code of the physician ordering the x-rays and requesting payment. If the independent laboratory requests payment, use type of supplier code "69".

10.9 - Miles/Times/Units/Services (MTUS)

(Rev. 1970, Issued: 05-21-10, Effective: 10-01-2010, Implementation: 10-04-10)

Miles/Times/Units/Services (MTUS) count and MTUS indicator fields are on Part B Physician/Supplier Claims. These fields are documented in the CMS National Claims History Data Dictionary.

Standard systems are to put MTUS count and MTUS indicators on all claims at the line item level.

The purpose of the MTUS Count Field on the line item is to document additional information reflecting certain volumes related to indicators. In most cases, the value in this field will be the same as in the Service Count Field on the line item; however, for services such as anesthesia the field values will differ. In this case, the service count field will likely contain a value of 1 for the occurrence of the surgery while the MTUS Count Field will contain the actual time units that the anesthesiologist spent with the patient in 15 minute increments or a fraction thereof.

The purpose of the MTUS Indicator Field is to indicate what the value entered into the MTUS Count Field means. There are 6 indicator values, as follows:

0 - No allowed services
1 - Ambulance transportation miles
2 - Anesthesia Time Units
3 - Services
4 - Oxygen units
5 - Units of Blood

Examples of how to code these fields are specified in §10.10.1 below.

10.9.1 - Methodology for Coding Number of Services, MTUS Count and MTUS Indicator Fields

(Rev. 1970, Issued: 05-21-10, Effective: 10-01-2010, Implementation: 10-04-10)

The following instructions should be used as a guide for coding the number of services, MTUS Count and MTUS Indicator fields on the Part B Physician/Supplier Claim. These fields are documented in the CMS National Claims History Data Dictionary as CWFB_SRVC_CNT, CWFB_MTUS_CNT, and CWFB_MTUS_IND_CD, respectively. Services not falling into examples B, C, E, or F should be coded as shown in example D (services/pricing units).

A. No Allowed Services – (CWFB_MTUS_IND_CD = 0)

For claims reporting no allowed services, the following example should be used to code the line item:

A total of 2 visits was reported for HCPCS code 99211: Office or other outpatient visit for the management of an established patient. Both services were denied.

Number of services: 2 (furnished)
MTUS (services): 0 (allowed)
MTUS indicator: 0

B. Ambulance Miles - (CWFB_MTUS_IND_CD = 1)

For claims reporting ambulance miles, the following example should be used to code the line item:

Mileage Reporting: A total of 10 miles (1 trip) was reported for HCPCS code A0425: Ground mileage, per statute mile.

Number of services: 10
MTUS (miles): 10
MTUS indicator: 1

C. Anesthesia Time Units - (CWFB_MTUS_IND_CD = 2)

For claims reporting anesthesia time units in 15-minute periods or fractions of 15-minute periods, the following example should be used to code the line item:

A total of 1 allowed service is reported for HCPCS code 00142: Anesthesia for procedures on eye; lens surgery. The anesthesiologist attended the patient for 35 minutes.

Number of services: 1
MTUS (time units): 23 (one decimal point implied) *****
MTUS indicator: 2

***** Two 15-minute periods + 1/3 of a 15-minute period equals 2.3

D. Services/Pricing Units - (CWFB_MTUS_IND_CD = 3)

For claims reporting a service or pricing unit, the following examples should be used to code the line item:

Example 1-A total of 2 visits was reported for HCPCS code 99211: Office or other outpatient visit for the management of an established patient.

Number of services: 2
MTUS (services): 2
MTUS indicator: 3

Example 2 - A total of 500 milligrams was administered for HCPCS code J0120: Injection, Tetracycline, up to 250 mg.

NOTE: The number of milligrams should not be reported in the service or MTUS fields. Instead, report the number of pricing units. In this case, up to 250 mg equals 1 unit/service. Thus, 500 mg equals 2 units/services.

Number of services: 2
MTUS (services): 2
MTUS indicator: 3

Example 3-A total of 24 cans was purchased, each containing 300 calories for HCPCS code B4150: Enteral Formulae, 100 calories.

NOTE: Neither number of cans nor the number of calories should be reported in the services or MTUS fields. Instead, report the number of pricing units. In this case, 100 calories equals 1 unit/service. Thus, 24 cans * 300 calories / 100 calories equals 72 units/services.

Number of services: 72
MTUS (services): 72
MTUS indicator: 3

E. Oxygen Services - (CWFB_MTUS_IND_CD = 4)

For claims reporting oxygen units, the following example should be used to code the line item:

A total of 2 allowed services was reported for HCPCS code E0441: Oxygen contents, gaseous, 1 month's supply = 1 unit. The claim reported a 2 month's supply of oxygen.

Number of services: 2
MTUS: 2
MTUS indicator: 4

F. Blood Services - (CWFB_MTUS_IND_CD = 5)

For claims reporting blood units, the following example should be used to code the line item:

A total of 6 units of blood (services) was furnished for HCPCS code P9010: Blood (whole), for transfusion, per unit. Two units were denied**.**

Number of services:	6 (furnished)
MTUS (units):	4 (allowed)
MTUS indicator:	5

20 – Patient's Request for Medicare Payment Form CMS-1490S

(Rev. 899, Issued: 03-31-06; Effective: 10-01-06; Implementation: 10-02-06)

This form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains only the first six comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Some enrollees may want to keep the original itemized physician and supplier bills for income tax or complementary insurance purposes. Photocopies of itemized bills are acceptable for Medicare deductible and payment purposes if there is no evidence of alteration. Social Security offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims.

Although §1848(g)(4) of the Act requires physicians and suppliers to submit Part B Medicare claims for services furnished on or after September 1, 1990, contractors continue to accept, process, and pay for covered services submitted by beneficiaries on a Form CMS-1490S if there is no clear indication that the service provider intends to file a claim. An itemized bill for services on or after September 1, 1990, which clearly indicates the physician or supplier intends to file a Part B claim for the patient, may be returned to the beneficiary.

For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so or if one of the following situations applies:

- DME purchases from private sources;
- Cases in which a physician/supplier does not possess information essential for filing an MSP claim. Assume this is the case if the beneficiary files an MSP claim and encloses the primary insurer's payment determination notice and there is no indication that the service provider was asked to file but refused to do so;
- Services paid under the indirect payment procedure;

- Foreign claims;

- Services furnished by sanctioned physicians and suppliers which are approved for payment to the beneficiary per the Program Integrity Manual (PIM); and

- Other unusual or unique situations that are evaluated on a case-by-case basis.

If the contractor approves 11 or more Form CMS-1490S claims in a calendar month for services performed on or after September 1, 1990, by the same physician or supplier, monitor the provider's claims submissions and take appropriate action.

The contractor continues to stock Form CMS-1490S and, upon request, furnish beneficiaries with these forms. (Beneficiaries need these forms to file claims for services that physicians/suppliers are not required to submit (e.g., services prior to September 1, 1990), or refuse to submit to Part B on their behalf.)

30 – Printing Standards and Print File Specifications Form CMS-1500

(Rev. 899, Issued: 03-31-06; Effective: 10-01-06; Implementation: 10-02-06)

The National Uniform Claims Committee (NUCC) has approved the printing standards for Form CMS-1500 (08-05) paper claim. These standards are as follows:

The Form CMS-1500 (08-05) is designed to accommodate 10-pitch Pica type, 6 lines per inch vertical and 10 characters per inch (cpi) horizontal. Once adjusted to the left and right, PICA Alignment blocks in the first print line and characters appear within form lines as shown in the print file matrix.

Also provided on the Form CMS-1500 (08-05) is a position bar. This is a thick horizontal line that is at the base of the PICA alignment Boxes.

The Form CMS-1500 (08-05) is used in four different styles. Any one of these four styles may be printed from two negatives in concurrence with the layout that was approved by the NUCC. The face/back negative furnished must be used for all parts.

Compliance with these standards is required to facilitate the use of image processing technology such as Optical Character Recognition (OCR), facsimile transmission, and image storing.

Cut Sheet:

Size - 8.5 by 11 inches (plus or minus .0625 inch) or 217mm by 279mm (plus or minus 2mm).

Print - Face and back, head to head.

Margins –

Face-The top margin from the top edge of the form to the first print position is 1.33 inches or 34mm. The left margin is 0.3 inches to the left end of the first print position.

Back - 0.25 inch head and foot, 0.25 inch left and right or 6.35 mm head and foot, 6.35 mm left and right.

Offset -The X and Y offset for margins must not vary by more than +/-0.1 inch or 2.54 mm from sheet to sheet.

The X offset refers to the horizontal distance from the left edge of the paper to the beginning of the printing. The Y offset refers to the vertical distance between the top of the paper and the beginning of the printing.

Askewity - The askewity of the printed image must be no greater than 0.15mm in 100mm.

Paper Stock - Basis weight 20# recycled 30% postconsumer waste, White Environmental Paper Alliance (EPA) or approved paper stock. Smoothness: FS to be (140-160), or equivalent stock.

Ink color – Face – (OCR-Red Ink) must be in Flint J-6983 Red OCR “dropout” ink or an exact match, formerly known as Sinclair Valentine). There is to be no contamination with “Black” ink or pigment. Printer must maintain proper ink reflections limits of the OCR reader specified by the purchaser.

Back – Same as face.

Titles - Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red “dropout” ink.

Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the PICA boxes is to be in black ink.

Two Part Snap-set:

Size - Dimensions are same as Cut Sheet (detached 8.5 by 11 inches), plus top stub (.5 to .75 inches).

Print –

Part 1 - Face and back - head to head.

Part 2 - Face and back - head to head.

Margins - Same as Cut Sheet.

Askewity - Same as Cut Sheet.

Stock –

Part 1 - Carbonless, 20 CB – Recycled White

Part 2 - Any color that will not interfere with scanning of Part 1 sheet.

Ink Color –

Part 1 - (OCR-Red Ink) must be in Flint J-6983 Red OCR “dropout” ink or an exact match.

Part 2 - Any color that will not interfere with scanning of Part 1 sheet.

Titles - Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red “dropout” ink.

Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the PICA boxes is to be in black ink.

Perforations - Perforate top stub for disassembly of parts.

One Part Marginally Punched Continuous Form:

Size - Same dimensions as for Cut Sheet, plus 0.5 inch left and right, (overall: 9.5 by 11 inches, detached: 8.5 by 11 inches).

Print - Face and back, head to head.

Margins - On detached sheet, same as for Cut Sheet.

Askewity - On detached sheet, same as for Cut Sheet.

Paper Stock - Same as for Cut Sheet.

Ink Color - Same as for Cut Sheet (OCR-Red Ink) must be in Flint J-6983 Red OCR “dropout” ink or an exact match.

Titles - Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red “dropout” ink.

Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the PICA boxes is to be in black ink.

Perforations - Marginally 0.5 inch left and right, tear line horizontally every 11 inches.

Two Part Marginally Punched Continuous Forms:

Size - Same dimensions as for Cut Sheet, plus 0.5 inch left and right, (overall: 9.5 by 11 inches, detached: 8.5 by 11 inches).

Print –

Part 1 –Face and back, head to head.

Part 2 –Face and back, head to head.

Margins - On detached sheet, same as for Cut Sheet.

Askewity - On detached sheet, same as for Cut Sheet.

Paper Stock –

Part 1 - Carbonless, 20 CB – Recycled White

Part 2 - Any color or weight that does not interfere with scanning of part 1 sheet. Suggest the following sequence:

Paper Weight:

1st part is 20 CB - OCR Bond

2nd part is 14 CFB (if not last part)

Last part is 15CF

CB = Coated Back (Carbonless black print)

CFB = Coated Front and Back (Carbonless black print)

CF = Coated Front (Carbonless black print)

Ink color –

Part 1 - Same as for cut sheet, (OCR-Red Ink) must be in Flint J-6983 Red OCR "dropout" ink or an exact match.

Part 2 - Any color that will not interfere with scanning of the part 1 sheet.

Titles - Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red “dropout” ink.

Symbol - The identifiable 1500 in a rectangle located in the upper left front of the form above the PICA boxes is to be in black ink.

Joining - Crimp left and right.

Perforations - Marginally 0.5 inch left and right, tear line horizontally every 11”.

NOTE: Users may determine the number of parts that are applicable to their needs. Up to four total parts are feasible on some printers; some other printers may limit the readability of multiple plies. Color of any titles if applicable: Are to be in the same ink as the form, Flint J6983 OCR Red “dropout” ink.

Symbol: NUCC requires the use of an approved Form CMS-1500 in the formats provided displaying the 1500 symbol as approved by the NUCC. All printing of Form CMS-1500 must occur in accordance with the NUCC requirements.

Form Name - CMS-1500 Health Insurance Paper Claim Form, Approved by the National Uniform Claims Committee (NUCC).

Form Identification**:** The lower right-hand margin contains the approved OMB numbers and should be consistent throughout.

No modification is to be made to the Form CMS-1500 (08-05) without prior approval from the NUCC and CMS.

Exhibit 1

(Rev. 1970, Issued: 05-21-10, Effective: 10-01-2010, Implementation: 10-04-10)

Form CMS-1500 (08/05) User Print File Specifications (Formerly Exhibit 2)

LINE	FIELD	LITERAL	FIELD TYPE*	BYTES	COLUMNS
1		Left printer alignment block	M	3	01-03
1		Right printer alignment block	M	3	77-79
3	1	Medicare	M	1	01
3	1	Medicaid	M	1	08
3	1	Tricare Champus	M	1	15
3	1	Champva	M	1	24
3	1	Group Health Plan	M	1	31
3	1	FECA Blk Lung	M	1	39
3	1	Other	M	1	45
3	1a	Insured's ID Number	A/N	29	50-78
5	2	Patient's Name (Last, First, MI)	A	28	01-28
5	3	Patient's Birth Date (Month)	N	2	31-32
5	3	Patient's Birth Date (Day)	N	2	34-35
5	3	Patient's Birth (Year)	N	4	37-40
5	3	Sex-Male	M	1	42
5	3	Sex-Female	M	1	47
5	4	Insured Name (Last, First, MI)	A	29	50-78
7	5	Patient's Address	A/N	28	01-28
7	6	Patient Relationship to Insured (Self)	M	1	33
7	6	Patient Relationship to Insured (Spouse)	M	1	38
7	6	Patient Relationship to Insured (Child)	M	1	42
7	6	Patient Relationship to Insured (Other)	M	1	47
7	7	Insured's Address	A/N	29	50-78
9	5	Patient's City	A	24	01-24
9	5	Patient's State	A	3	26-28
9	8	Patient Status (Single)	M	1	35
9	8	Patient Status (Married)	M	1	41
9	8	Patient Status (Other)	M	1	47
9	7	Insured's City	A	23	50-72

9	**7**	**Insured's State**	**A**	**4**	**74-77**
11	**5**	**Patient's ZIP Code**	**N**	**12**	**01-12**
11	**5**	**Patient's Area Code**	**N**	**3**	**15-17**
11	**5**	**Patient's Phone Number**	**N**	**10**	**19-28**
11	**8**	**Patient Status (Employed)**	**M**	**1**	**35**
11	**8**	**Patient Status (Full Time Student)**	**M**	**1**	**41**
11	**8**	**Patient Status (Part Time Student)**	**M**	**1**	**47**
11	**7**	**Insured's ZIP Code**	**N**	**12**	**50-61**
11	**7**	**Insured's Area Code**	**N**	**3**	**65-67**
11	**7**	**Insured's Phone Number**	**N**	**10**	**69-78**
13	**9**	**Other Insured's Name (Last, First, MI)**	**A**	**28**	**01-28**
13	**11**	**Insured's Policy, Group or FECA Number**	**A/N**	**29**	**50-78**
15	**9a**	**Other Insured's Policy or Group Number**	**A/N**	**28**	**01-28**
15	**10a**	**Condition Related (Employment C/P, Yes)**	**M**	**1**	**35**
15	**10a**	**Condition Related (Employment C/P, No)**	**M**	**1**	**41**
15	**11a**	**Insured's Date of Birth (Month)**	**N**	**2**	**53-54**
15	**11a**	**Insured's Date of Birth (Day)**	**N**	**2**	**56-57**
15	**11a**	**Insured's Date of Birth (Year)**	**N**	**4**	**59-62**
15	**11a**	**Sex-Male**	**M**	**1**	**68**
15	**11a**	**Sex-Female**	**M**	**1**	**75**
17	**9b**	**Other Insured's Date of Birth (Month)**	**N**	**2**	**02-03**
17	**9b**	**Other Insured's Date of Birth (Day)**	**N**	**2**	**05-06**
17	**9b**	**Other Insured's Date of Birth (Year)**	**N**	**4**	**08-11**
17	**9b**	**Sex-Male**	**M**	**1**	**18**
17	**9b**	**Sex-Female**	**M**	**1**	**24**
17	**10b**	**Condition Related To: (Auto Accident-Yes)**	**M**	**1**	**35**
17	**10b**	**Condition Related To: (Auto Accident-No)**	**M**	**1**	**41**
17	**10b**	**Condition Related To: (Auto Accident-State)**	**A**	**2**	**45-46**
17	**11b**	**Insured's Employer's Name or School Name**	**A/N**	**29**	**50-78**
19	**9c**	**Other Insured's Employer's Name or School**	**A/N**	**28**	**01-28**
19	**10c**	**Other Accident (Yes)**	**M**	**1**	**35**
19	**10c**	**Other Accident (No)**	**M**	**1**	**41**
19	**11c**	**Insured's Insurance Plan or PayerID**	**A/N**	**29**	**50-78**
21	**9d**	**Other Insured's Insurance Plan Name or PayerID**	**A/N**	**28**	**01-28**
21	**10d**	**(Reserved for Local Use)**	**A/N**	**19**	**30-48**

21	**11d**	**Another Benefit Health Plan (Yes)**	**M**	**1**	**52**	
21	**11d**	**Another Benefit Health Plan (No)**	**M**	**1**	**57**	
25	**12**	**Left Blank for Patient's Signature & Date**				
25	**13**	**Left Blank for Insured's Signature**				
27	**14**	**Date of Current Illness, Injury, Pregnancy (Month)**	**N**	**2**	**02-03**	
27	**14**	**Date of Current Illness, Injury, Pregnancy (Day)**	**N**	**2**	**05-06**	
27	**14**	**Date of Current Illness, Injury, Pregnancy - (Year)**	**N**	**4**	**08-11**	
27	**15**	**First Date Has Had Same or Similar Illness (Month)**	**N**	**2**	**37-38**	
27	**15**	**First Date Has Had Same or Similar Illness (Day)**	**N**	**2**	**40-41**	
27	**15**	**First Date Has Had Same or Similar Illness - (Year)**	**N**	**4**	**43-46**	
27	**16**	**Dates Patient Unable to Work (From Month)**	**N**	**2**	**54-55**	
27	**16**	**Dates Patient Unable to Work (From Day)**	**N**	**2**	**57-58**	
27	**16**	**Dates Patient Unable to Work (From Year)**	**N**	**4**	**60-63**	
27	**16**	**Dates Patient Unable to Work (To Month)**	**N**	**2**	**68-69**	
27	**16**	**Dates Patient Unable to Work (To Day)**	**N**	**2**	**71-72**	
27	**16**	**Dates Patient Unable to Work (To Year)**	**N**	**4**	**74-77**	
28	**17a**	**Legacy Qualifier/Provider Number of Referring Physician**		**A/N**	**19**	**30-48**
29	**17**	**Name of Referring Physician or Other Source**	**A**	**26**	**01-26**	
29	**17b**	**NPI Number of Referring Physician**	**N**	**17**	**32-48**	
29	**18**	**Hospitalization Related Current Svcs (From Month)**		**N**	**2**	**54-55**
29	**18**	**Hospitalization Related Current Svcs (From Day)**	**N**	**2**	**57-58**	
29	**18**	**Hospitalization Related Current Svcs (From Year)**	**N**	**4**	**60-63**	
29	**18**	**Hospitalization Related Current Svcs (To Month)**	**N**	**2**	**68-69**	
29	**18**	**Hospitalization Related Current Svcs (To Day)**	**N**	**2**	**71-72**	
29	**18**	**Hospitalization Related Current Svcs (To Year)**	**N**	**4**	**74-77**	
30	**19**	**Reserved for Local Use**	**A/N**	**35**	**14-48**	
31	**19**	**Reserved for Local Use**	**A/N**	**48**	**01-48**	
31	**20**	**Outside Lab (Yes)**	**M**	**1**	**52**	
31	**20**	**Outside Lab (No)**	**M**	**1**	**57**	
31	**20**	**$ Charges**	**N**	**8/8**	**62-78**	
33	**21.1**	**Diagnosis or Nature of Illness or Injury (Code)**	**A/N**	**8**	**03-10**	
33	**21.3**	**Diagnosis or Nature of Illness or Injury (Code)**	**A/N**	**8**	**30-37**	
33	**22**	**Medicaid Resubmission Code**	**A/N**	**11**	**50-60**	
33	**22.2**	**Original Reference Number**	**A/N**	**18**	**61-78**	
35	**21.2**	**Diagnosis or Nature of Illness or Injury (Code)**	**A/N**	**8**	**03-10**	

35	**21.4**	**Diagnosis or Nature of Illness or Injury (Code)**	**A/N**	**8**	**30-37**
35	**23**	**Prior Authorization Number**	**A/N**	**29**	**50-78**
38	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
38	**24.1i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**
38	**24.1j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
39	**24.1a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
39	**24.1a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
39	**24.1a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
39	**24.1a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
39	**24.1a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
39	**24.1a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
39	**24.1b**	**Place of Service**	**A/N**	**2**	**19-20**
39	**24.1c**	**EMG**	**A**	**2**	**22-23**
39	**24.1d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	**6**	**25-30**
39	**24.1d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
39	**24.1d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	**2**	**36-37**
39	**24.1d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**
39	**24.1d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	**2**	**42-43**
39	**24.1e**	**Diagnosis Pointer**	**N**	**4**	**45-48**
39	**24.1f**	**$ Charges**	**N**	**8**	**50-57**
39	**24.1g**	**Days or Units**	**N**	**3**	**59-61**
39	**24.1h**	**EPSDT Family Plan**	**A**	**1**	**63**
39	**24.1i**	**Legacy Qualifier Rendering Provider (Leave Blank)**		**A/N**	**0**
39	**24.1j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
40	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
40	**24.2i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**
40	**24.2j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
41	**24.2a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
41	**24.2a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
41	**24.2a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
41	**24.2a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
41	**24.2a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
41	**24.2a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
41	**24.2b**	**Place of Service**	**A/N**	**2**	**19-20**
41	**24.2c**	**EMG**	**A**	**2**	**22-23**

41	**24.2d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	**6**	**25-30**
41	**24.2d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
41	**24.2d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	**2**	**36-37**
41	**24.2d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**
41	**24.2d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	**2**	**42-43**
41	**24.2e**	**Diagnosis Pointer**	**N**	**4**	**45-48**
41	**24.2f**	**$ Charges**	**N**	**8**	**50-57**
41	**24.2g**	**Days or Units**	**N**	**3**	**59-61**
41	**24.2h**	**EPSDT Family Plan**	**A**	**1**	**63**
41	**24.2i**	**Legacy Qualifier Rendering Provider (Leave Blank)**		**A/N**	**0**
41	**24.2j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
42	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
42	**24.3i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**
42	**24.3j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
43	**24.3a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
43	**24.3a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
43	**24.3a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
43	**24.3a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
43	**24.3a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
43	**24.3a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
43	**24.3b**	**Place of Service**	**A/N**	**2**	**19-20**
43	**24.3c**	**EMG**	**A**	**2**	**22-23**
43	**24.3d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	**6**	**25-30**
43	**24.3d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
43	**24.3d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	**2**	**36-37**
43	**24.3d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**
43	**24.3d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	**2**	**42-43**
43	**24.3e**	**Diagnosis Pointer**	**N**	**4**	**45-48**
43	**24.3f**	**$ Charges**	**N**	**8**	**50-57**
43	**24.3g**	**Days or Units**	**N**	**3**	**59-61**
43	**24.3h**	**EPSDT Family Plan**	**A**	**1**	**63**
43	**24.3i**	**Legacy Qualifier Rendering Provider (Leave Blank)**		**A/N**	**0**
43	**24.3j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
44	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
44	**24.4i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**

44	**24.4j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
45	**24.4a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
45	**24.4a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
45	**24.4a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
45	**24.4a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
45	**24.4a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
45	**24.4a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
45	**24.4b**	**Place of Service**	**A/N**	**2**	**19-20**
45	**24.4c**	**EMG**	**A**	**2**	**22-23**
45	**24.4d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	**6**	**25-30**
45	**24.4d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
45	**24.4d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	**2**	**36-37**
45	**24.4d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**
45	**24.4d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	**2**	**42-43**
45	**24.4e**	**Diagnosis Pointer**	**N**	**4**	**45-48**
45	**24.4f**	**$ Charges**	**N**	**8**	**50-57**
45	**24.4g**	**Days or Units**	**N**	**3**	**59-61**
45	**24.4h**	**EPSDT Family Plan**	**A**	**1**	**63**
45	**24.4i**	**Legacy Qualifier Rendering Provider (Leave Blank)**		**A/N**	**0**
45	**24.4j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
46	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
46	**24.5i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**
46	**24.5j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
47	**24.5a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
47	**24.5a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
47	**24.5a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
47	**24.5a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
47	**24.5a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
47	**24.5a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
47	**24.5b**	**Place of Service**	**A/N**	**2**	**19-20**
47	**24.5c**	**EMG**	**A**	**2**	**22-23**
47	**24.5d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	**6**	**25-30**
47	**24.5d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
47	**24.5d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	**2**	**36-37**
47	**24.5d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**

47	**24.5d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	**2**	**42-43**
47	**24.5e**	**Diagnosis Pointer**	**N**	**4**	**45-48**
47	**24.5f**	**$ Charges**	**N**	**8**	**50-57**
47	**24.5g**	**Days or Units**	**N**	**3**	**59-61**
47	**24.5h**	**EPSDT Family Plan**	**A**	**1**	**63**
47	**24.5i**	**Legacy Qualifier Rendering Provider (Leave Blank)**		**A/N**	**0**
47	**24.5j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
48	**24**	**Line Detail Narrative**	**A/N**	**63**	**01-63**
48	**24.6i**	**Legacy Qualifier Rendering Provider**	**A/N**	**2**	**65-66**
48	**24.6j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
49	**24.6a**	**Date(s) of Service - (From Month)**	**N**	**2**	**01-02**
49	**24.6a**	**Date(s) of Service - (From Day)**	**N**	**2**	**04-05**
49	**24.6a**	**Date(s) of Service - (From Year)**	**N**	**2**	**07-08**
49	**24.6a**	**Date(s) of Service - (To Month)**	**N**	**2**	**10-11**
49	**24.6a**	**Date(s) of Service - (To Day)**	**N**	**2**	**13-14**
49	**24.6a**	**Date(s) of Service - (To Year)**	**N**	**2**	**16-17**
49	**24.6b**	**Place of Service**	**A/N**	**2**	**19-20**
49	**24.6c**	**EMG**	**A**	**2**	**22-23**
49	**24.6d**	**Procedures, Svcs or Supplies (CPT/HCPCS)**	**A/N**	**6**	**25-30**
49	**24.6d**	**Procedures, Svcs or Supplies (Modifier 1)**	**A/N**	**2**	**33-34**
49	**24.6d**	**Procedures, Svcs or Supplies (Modifier 2)**	**A/N**	**2**	**36-37**
49	**24.6d**	**Procedures, Svcs or Supplies (Modifier 3)**	**A/N**	**2**	**39-40**
49	**24.6d**	**Procedures, Svcs or Supplies (Modifier 4)**	**A/N**	**2**	**42-43**
49	**24.6e**	**Diagnosis Pointer**	**N**	**4**	**45-48**
49	**24.6f**	**$ Charges**	**N**	**8**	**50-57**
49	**24.6g**	**Days or Units**	**N**	**3**	**59-61**
49	**24.6h**	**EPSDT Family Plan**	**A**	**1**	**63**
49	**24.6i**	**Legacy Qualifier Rendering Provider (Leave Blank)**		**A/N**	**0**
49	**24.6j**	**Legacy Provider Number Rendering Provider**	**A/N**	**11**	**68-78**
51	**25**	**Federal Tax ID Number**	**N**	**15**	**1-15**
51	**25**	**Federal Tax ID Number (SSN)**	**M**	**1**	**17**
51	**25**	**Federal Tax ID Number (EIN)**	**M**	**1**	**19**
51	**26**	**Patient's Account Number**	**A/N**	**14**	**23-36**
51	**27**	**Accept Assignment (Yes)**	**M**	**1**	**38**
51	**27**	**Accept Assignment (No)**	**M**	**1**	**43**

51	**28**	**Total Charge**	**N**	**9**	**51-59**
51	**29**	**Amount Paid**	**N**	**8**	**62-69**
51	**30**	**Balance Due**	**N**	**8**	**71-78**
52	**33**	**Billing Provider Phone Number Area Code**	**N**	**3**	**66-68**
52	**33**	**Billing Provider Phone Number**	**N**	**9**	**70-78**
53	**32**	**Name of Facility Where Svcs Rendered**	**A/N**	**26**	**23-48**
53	**33**	**Physician/Supplier Billing Name**	**A/N**	**29**	**50-78**
54	**32**	**Address of Facility Where Svcs Rendered**	**A/N**	**26**	**23-48**
54	**33**	**Physician/Supplier Address**	**A/N**	**29**	**50-78**
55	**31**	**Left Blank for Signature Physician/Supplier**			
55	**32**	**City, State and ZIP Code of Facility**	**A/N**	**26**	**23-48**
55	**33**	**City, State and ZIP Code of Billing Provider**	**A/N**	**29**	**50-78**
56	**32a**	**Facility NPI Number**	**N**	**10**	**24-33**
56	**32b**	**Facility Qualifier and Legacy Number**	**A/N**	**14**	**35-48**
56	**33a**	**Billing Provider NPI Number**	**N**	**10**	**51-60**
56	**33b**	**Billing Provider Qualifier and Legacy Number**	**A/N**	**17**	**62-78**

*** M = mark (X), A = alpha, N = numeric**

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R3255CP	05/08/2015	Correction to the Multi-Carrier System (MCS) Editing on the Service Location National Provider Identifier (NPI) Reported for Anti-Markup and Reference Laboratory Claims	10/05/2015	9150
R3177CP	01/30/2015	Updating CMS IOM 100-04, Chapter 26 with Specialty Code B1	03/02/2015	9001
R3103CP	11/03/2014	Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims	04/06/2015	8806
R3098CP	10/21/2014	Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims – Rescinded and replaced by Transmittal 3103	04/05/2014	8806
R3083CP	10/02/2014	Form CMS-1500 Instructions: Revised for Form Version 02/12	01/06/2014	8509
R3073CP	09/23/2014	New Physician Specialty Code for Interventional Cardiology	01/05/2015	8812
R3061CP	09/04/2014	New Physician Specialty Code for Interventional Cardiology – Rescinded and replaced by Transmittal 3073	01/05/2015	8812
R3048CP	08/22/2014	New Physician Specialty Code for Interventional Cardiology – Rescinded and replaced by Transmittal 3061	01/05/2015	8812
R3047CP	08/22/2014	Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims – Rescinded and replaced by Transmittal 3098	01/05/2014	8806
R2984CP	07/11/2014	Beneficiary Signature Requirements for Ambulance Services	08/12/2014	8760

Rev #	Issue Date	Subject	Impl Date	CR#
R2842CP	12/27/2013	Form CMS-1500 Instructions: Revised for Form Version 02/12 – Rescinded and replaced by Transmittal 3083	01/06/2014	8509
R2814CP	11/15/2013	2014 Annual Type of Service (TOS) Update	01/06/2014	8519
R2744CP	07/24/2013	Type of Service (TOS) Corrections 2013	10/07/2013	8392
R2738CP	07/12/2013	Type of Service (TOS) Corrections 2013 – Rescinded and replaced by Transmittal 2744	10/07/2013	8392
R2721CP	06/12/2013	New Non-Physician Specialty Code for Complimentary Insurer	10/07/2013	8282
R2697CP	05/03/2013	New Non-Physician Specialty Code for Complimentary Insurer – Rescinded and replaced by Transmittal 2721	10/07/2013	8282
R2679CP	03/29/2013	Revised and Clarified Place of Service (POS) Coding Instructions	04/01/2013	7631
R2613CP	12/14/2012	Revised and Clarified Place of Service (POS) Coding Instructions – Rescinded and replaced by Transmittal 2679	04/01/2013	7631
R2614CP	12/14/2012	Updated Billing Requirements for Outpatient Therapy Services -- Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012	11/27/2012	8097
R2602CP	11/30/2012	New Place of Service (POS) Code for Place of Employment/Worksite	04/01/2013	8125
R2598CP	11/23/2012	Annual Type of Service (TOS) Update	01/07/2013	8082
R2571CP	10/26/2012	Updated Billing Requirements for Outpatient Therapy Services – Middle Class Tax Relief and Jobs Creation Act (MCTRJCA) of 2012 – Rescinded and replaced by Transmittal 2614	11/27/2012	8097
R2570CP	10/26/2012	Annual Type of Service (TOS) Update – Rescinded and replaced by Transmittal 2598	01/07/2013	8082

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R2563CP	10/11/2012	Revised and Clarified Place of Service (POS) Coding Instructions – Rescinded and replaced by Transmittal 2613	04/01/2013	7631
R2561CP	09/28/2012	Revised and Clarified Place of Service (POS) Coding Instructions – Rescinded and replaced by Transmittal 2563	04/01/2013	7631
R2516CP	08/10/2012	New Non-Physician Specialty Code for Centralized Flu	01/07/2013	7884
R2462CP	04/27/2012	New Physician Specialty Code for Sleep Medicine and Sports Medicine	10/01/2012	7600
R2435CP	03/29/2012	Revised and Clarified Place of Service (POS) Coding Instructions – Rescinded and replaced by Transmittal 2561	10/01/2012	7631
R2407CP	02/03/2012	Revised and Clarified Place of Service (POS) Coding Instructions – Rescinded and replaced by Transmittal 2435	04/02/2012	7631
R2375CP	12/22/2011	Annual Type of Service (TOS) Update	01/03/2012	7586
R2325CP	10/26/2011	Annual Type of Service (TOS) Update – Rescinded and replaced by Transmittal 2375	01/03/2012	7586
R2284CP	08/26/2011	Clarification to Chapter 26, Section 10-4-Items 14-33-Provider of Service or Supplier Information	09/26/2011	7538
R2261CP	07/29/2011	Affordable Care Act – Section 3113 – Laboratory Demonstration for Certain Complex Diagnostic Tests (This CR fully rescinds and replaces CR 7413)	01/03/2012	7516
R2248CP	06/24/2011	New Specialty Code for Advanced Diagnostic Imaging Accreditation	04/01/2011	7175
R2226CP	05/20/2011	Affordable Care Act-Section 3113-Laboratory Demonstration for Certain Complex	01/03/2012	7413

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		Diagnostic Tests (This CR fully rescinds and replaces CR 7278) – This CR rescinded and replaced by CR 7516, Transmittal 2261		
R2204CP	04/29/2011	Type of Service (TOS) Corrections	10/03/2011	7407
R2192CP	04/12/2011	New Specialty Code for Advanced Diagnostic Imaging Accreditation – Rescinded and replaced by Transmittal 2248	07/05/2011	7175
R2191CP	04/08/2011	New Specialty Code for Advanced Diagnostic Imaging Accreditation – Rescinded and replaced by Transmittal 2192	07/05/2011	7175
R2173CP	03/11/2011	Affordable Care Act – Section 3113 – Laboratory Demonstration for Certain Complex Diagnostic Tests – Rescinded and replaced by CR 7413, Transmittal 2226	7/05/2011	7278
R2162CP	02/22/2011	Updates to the Internet Only Manual Pub. 100-04, Chapter 1 - General Billing Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set	03/21/2011	7018
R2144CP	01/28/2011	Affordable Care Act – Section 3113 – Laboratory Demonstration for Certain Complex Diagnostic Tests – Rescinded and replaced by Transmittal 2173	7/05/2011	7278
R2126CP	12/23/2010	Annual Type of Service (TOS) Update	01/03/2011	7185
R2124CP	12/23/2010	Updates to the Internet Only Manual Pub. 100-04, Chapter 1 - General Billing Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set - Rescinded and replaced by Transmittal 2162	01/25/2011	7018
R2103CP	11/19/2010	Fractional Mileage Units Submitted on Ambulance Claims	01/03/2011	7065

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R2098CP	11/19/2011	New Physician Specialty Codes for Cardiac Electrophysiology and Sports Medicine	04/04/2011	7209
R2079CP	10/29/2010	New Specialty Code for Advanced Diagnostic Imaging Accreditation – Rescinded and replaced by Transmittal 2191	04/04/2011	7175
R2072CP	10/22/2010	Annual Type of Service (TOS) Update – Rescinded and replaced by Transmittal 2126	01/03/2011	7185
R2065CP	10/15/2010	Fractional Mileage Units Submitted on Ambulance Claims – Rescinded and replaced by Transmittal 2103	01/03/2011	7065
R2041CP	08/31/2010	Revisions to Claims Processing Instructions for Services Rendered in Place of Service Home	01/03/2011	6947
R2035CP	08/27/2010	Change Physician Specialty Code 12 to Osteopathic Manipulative Medicine	01/03/2011	6890
R2030CP	08/20/2010	New Durable Medical Equipment, Prosthetics. Orthotics, and Supplies (DMEPOS) Specialty Code for Ocularists	01/03/2011	6891
R2029CP	08/13/2010	Fractional Mileage Units Submitted on Ambulance Claims – Rescinded and replaced by Transmittal 2065	01/03/2011	7065
R2015CP	07/30/2010	Revisions to Claims Processing Instructions for Services Rendered in Place of Service Home - Rescinded and replaced by Transmittal 2041.	01/03/2011	6947
R2003CP	07/19/2010	New Physician Specialty Code for Geriatric Psychiatry	04/05/2010	6533
R1974CP	05/21/2010	Cardiac Rehabilitation and Intensive Cardiac Rehabilitation	10/04/2010	6850
R1970CP	05/21/2010	Updated Form CMS-1500 Information	10/04/2010	6929

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R1931CP	03/12/2010	Revision of the Internet Only Manual (IOM) to Remove References to “Purchased Diagnostic Test” and Replace With Language Consistent With the Anti-Markup Rule	06/14/2010	6627
R1910CP	02/05/2010	Type of Service (TOS) Corrections	04/05/2010	6835
R1873CP	12/11/2009	Place of Service (POS) and Date of Service (DOS) Instructions for the Interpretation (Professional Component) and Technical Component of Diagnostic Tests - Rescinded	01/04/2010	6375
R1869CP	12/11/2009	New Place of Service (POS) Code for Walk-in Retail Health Clinic	03/11/2010	6752
R1836CP	10/27/2009	New Physician Specialty Code for Geriatric Psychiatry	04/05/2010	6533
R1830CP	10/16/2009	Annual Type of Service (TOS) Update	01/04/2010	6693
R1823CP	10/02/2009	Place of Service (POS) and Date of Service (DOS) Instructions for the Interpretation (Professional Component) and Technical Component of Diagnostic Tests – Rescinded and replaced by Transmittal 1873	01/04/2010	6375
R1806CP	08/28/2009	October 2009 Update to the Ambulatory Surgical Center (ASC) Payment System; Summary of Payment Policy Changes	10/05/2009	6629
R1725CP	05/01/2009	Requirements for Specialty Codes	07/06/2009	6303
R1715CP	04/24/2009	New Physician Specialty Code for Hospice and Palliative Care	10/05/2009	6311
R1686CP	02/20/2009	New Non-Physician Practitioner Specialty Code for Speech Language Pathologists	07/06/2009	6292
R1638CP	11/20/2008	Annual Type of Service (TOS) Update	01/05/2009	6272
R1637CP	11/14/2008	Annual Type of Service (TOS) Update -	01/05/2009	6272

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		Rescinded and replaced by Transmittal 1638		
R1586CP	09/05/2008	Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines	10/06/2008	6079
R1552CP	07/18/2008	VMS Recognition of New Specialty Codes for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) With Pedorthic Personnel, Medical Supply Companies With Pedorthic Personnel, and Rehabilitation Agencies. (DME MACs Only)	01/05/2009	5930
R1481CP	03/21/2008	Type of Service (TOS) Corrections	04/07/2008	5977
R1432CP	02/01/2008	Medicare Fee for Service Legacy Provider IDs Prohibited on Form CMS-1500 and Form CMS-1450 (UB-04) Claims	04/07/2008	5858
R1420CP	01/25/2008	Clarification Regarding the Coordination of Benefits Agreement (COBA) Medigap Claim-Based Crossover Process	02/01/2008	5837
R1412CP	01/11/2008	Reporting of Hematocrit or Hemoglobin Levels on All Claims for the Administration of Erythropoiesis Stimulating Agents (ESAs), Implementation of New Modifiers for Non-ESRD Indications, and Reporting of Hematocrit/Hemoglobin Levels on all Non-ESRD, Non-ESA Claims Requesting Payment for Anti-Anemia Drugs	04/07/2008	5699
R1410CP	01/11/2008	Annual Type of Service (TOS) Update	01/07/2008	5838
R1401CP	12/21/2007	Medicare Shared Systems Modifications Necessary to Accept and Crossover to Medicaid National Drug Codes (NDC) And Corresponding Quantities Submitted on Form CMS-1500 Paper Claims	04/07/2008	5835
R1398CP	12/19/2007	Annual Type of Service (TOS) Update (Replaced by Transmittal 1410)	01/07/2008	5838

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R1393CP	12/14/2007	Revised Guidance for Completing Form CMS-1500	01/07/2008	5749
R1369CP	11/02/2007	Crossover of Assignment of Benefits Indicator (CLM08) From Paper Claim Input	04/07/2008	5780
R1366CP	11/02/2007	Update to Place of Service (POS) Code Set: New Code for Temporary Lodging	04/07/2008	5777
R1325CP	08/29/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes	01/07/2008	5680
R1308CP	07/20/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes – Replaced by Transmittal 1325 – Replaced by Transmittal 1325	01/07/2008	5680
R1215CP	03/30/2007	Revisions to Form CMS-1500 Submission Requirements	04/30/2007	5489
R1191CP	03/02/2007	Type of Service (TOS) Corrections	04/02/2007	5510
R1086CP	10/27/2006	Annual Type of Service (TOS) Update	01/02/2007	5361
R1058CP	09/15/2006	Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (08/05)	01/02/2007	5060
R1049CP	09/01/2006	Update to the Place of Service (POS) Code Set to Add a Code for Prison/Correctional Facility	01/02/2007	4316
R1010CP	07/28/2006	Additional Requirements Necessary to Implement the Revised Health Insurance Claim Form CMS-1500 (08/05)	01/02/2007	5060
R980CP	06/14/2006	Changes Conforming to CR 3648 Instructions for Therapy Services - Replaces Rev. 941	10/02/2006	4014
R941CP	05/05/2006	Changes Conforming to CR 3648 Instructions	10/02/2006	4014

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		for Therapy Services		
R899CP	03/31/2006	Revised Heath Insurance Claim Form CMS-1500	10/02/2006	4293
R870CP	02/24/2006	Type of Service (TOS) Corrections	04/03/2006	4322
R735CP	10/31/2005	Processing All Diagnosis Codes Reported on Claims Submitted to Carriers	04/03/2006	4097
R727CP	10/28/2005	Annual Type of Service (TOS)	01/03/2006	4145
R549CP	04/29/2005	Update to the Place of Service (POS) Code Set to Add a Code for Pharmacy	10/03/2005	3819
R511CP	03/28/2005	Type of Service (TOS) Corrections	04/18/2005	3788
R506CP	03/18/2005	Updated Manual Instructions for Item 24G (Days or Units)	07/01/2005	3753
R476CP	02/18/2005	Type of Service (TOS) Corrections	04/04/2005	3717
R400CP	12/16/2004	Incorrect Reporting of MTUS Indicator When Drugs are Billed Using an NDC Code	04/04/2005	3435
R359CP	11/04/2004	2005 Annual Type of Service (TOS)	01/03/2005	3519
R349CP	10/29/2004	2005 Annual Type of Service (TOS)	01/03/2005	3519
R335CP	10/29/2004	Correction of Reporting of MTUS Indicator When Drugs are Billed Using an NDC Code	04/04/2005	3435
R317CP	10/22/2004	Clarification to Chapter 26	N/A	3431
R228CP	07/16/2004	Lab and Carrier Processing of Claims for Reference Lab Services When there is No Face-to-Face Encounter with the Beneficiary	08/16/2004	3267
R153CP	04/30/2004	Correction of Type of Service (TOS) Inconsistencies	10/04/2004	3189

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R148CP	04/23/2004	Describing the Identity of the Ordering and Supervising Physician on Form CMS-1500 Paper Claim	05/24/2004	3138
R145CP	04/23/2004	Deletion of the Data Element Requirements Matrix for Carriers from Chapter 1 and Chapter 26	05/24/2004	3164
R121CP	03/19/2004	Manualization of Program Memorandum B-03-040, CR 2730, Dated May 16, 2003, Regarding Place of Service (POS) Codes and Revises the Wording of the Group Home Code, 14	04/01/2004	3087
R108CP	02/27/2004	Correction of Type of Service (TOS) Inconsistencies in CR 2929	03/29/2004	3018
R005CP	10/10/2003	Update to 2004 HCPCS/Type of Service Crosswalk	01/01/2004	2929
R001CP	10/01/2003	Initial Publication of Manual	NA	NA

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