Medicare Claims Processing Manual

Chapter 26 - Completing and Processing

Form CMS-1500 Data Set

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(Rev. 148, 04-23-04)

(Rev. 228, 07-16-04)

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10 - Health Insurance Claim Form CMS-1500

(Rev. 1, 10-01-03)

B3-3002, B3-4020, B4-2010, B3-3005.1.B, B3-3005.4

The Form CMS-1500 (Health Insurance Claim Form) is sometimes referred to as the AMA (American Medical Association) form. The Form CMS-1500 is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance suppliers), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc. To purchase them from the U.S. Government Printing Office, call (202) 512-1800. An electronic version is available at http://www.cms.hhs.gov/providers/edi/edi5.asp.

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare and Medicaid programs for claims from physicians and suppliers. It has also been adopted by the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) and has received the approval of the American Medical Association (AMA) Council on Medical Services.

There are a number of Part B services that have special limitations on payments or that require special methods of benefit computation. Carriers should monitor their processing systems to insure that they recognize the procedure codes that involve services with special payment limitations or calculation requirements. They should be able to identify separately billed procedure codes for physician services which are actually part of a global procedure code to prevent a greater payment than if the procedure were billed globally.

The following instructions must be completed or are required for a Medicare claim. Carriers should provide information on completing the Form CMS-1500 to all physicians and suppliers in their area at least once a year.

Providers may use these instructions for completing this form. The Form CMS-1500 has space for physicians and suppliers to provide information on other health insurance. This information can be used by carriers to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment, or whether there is a Medigap policy under which payments are made to a participating physician or supplier. (See the Medicare Secondary Payer Manual, Chapter 3, and this manual, Chapter 28).

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) are effective for providers and suppliers as of 10/01/98.

Providers and suppliers have the option of entering either 6 or 8-digit dates 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 all these fields. For instance, a provider of service or supplier will not 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)	Indicate that 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)
(MMDDYY) or (MMDDCCYY)	Indicates that 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. 228, Issued 07-16-04, Effective: December 8, 2003/Implementation: August 16, 2004)

B3-3005.2, B3-3005.4, B3-4020.1, B4-2010.1, TR-1712

Item 1 - Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, 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 and 11 are completed.

Item 8 - Check the appropriate box for the patient's marital status and whether employed or a student.

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 Beneficiary 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 carrier 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 proceeded by **MEDIGAP, MG, or MGAP**.

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

Item 9b - Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.

Item 9c - Leave blank if a Medigap PayerID is entered in item 9d. 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 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.

If the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, the participating provider of service or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

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 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 of Form CMS-1500, 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 Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.

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

(Rev. 1, 10-01-03)

B3-3005.2, B3-3005.4, B3-4020.1, B3-2010.1

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

Item 11b - 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."

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 Field 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, "General Billing Requirements 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, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless 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 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. 148, 04-23-04)

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

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

Item 15 - Leave blank. Not required by Medicare.

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

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

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

Ordering physician - is a physician *or, when appropriate, a non-physician practitioner* who orders nonphysician services for the patient. *See Pub. 100-02, 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 and Unique Physician Identification Number (UPIN). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services;
- Diagnostic radiology services;

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

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

When a service is incident to the service of a physician or non-physician practitioner, the name and assigned UPIN (the NPI shall be used when implemented) of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17a.

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

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN (the NPI will be used when implemented) of the physician supervising the limited licensed practitioner appear in items 17 and 17a.

When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.

Enter the original ordering/referring physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the first claim form.

Enter the ordering (performing) physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).

Surrogate UPINs - If the ordering/referring physician has not been assigned a UPIN (the NPI will be used when implemented), one of the surrogate UPINs listed below be used in item 17a. The surrogate UPIN used depends on the circumstances and is used only until the physician is assigned a UPIN. Enter the physician's name in item 17 and the surrogate UPIN in item 17a. All surrogate UPINs, with the exception of retired physicians (RET00000), are temporary and may be used only until a UPIN is assigned. The contractor monitor claims with surrogate UPINs.

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

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

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

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

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

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

Item 17a - Enter the CMS assigned UPIN (the NPI will be used when implemented) of the referring/ordering physician listed in item 17.

When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 be used for each ordering/referring physician.

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

- Residents who are issued a UPIN in conjunction with activities outside of their residency status use that UPIN. For interns and residents without UPINs, use the 8-character surrogate UPIN RES00000;

- Retired physicians who were not issued a UPIN may use the surrogate RET00000;

- Physicians serving in the Department of Veterans Affairs or the U.S. Armed Services may use VAD00000;

- Physicians serving in the Public Health or Indian Health Services may use PHS00000;

- The law extends coverage and direct payment in non-Metropolitan Statistical Areas to practitioners who are State licensed to order medical services or refer patients to Medicare providers without the approval or collaboration of a supervising physician. Billers use the surrogate UPIN "UPIN0000" on claims involving services ordered/referred by nurse practitioners, clinical nurse specialists, or any nonphysician practitioner who is State licensed to order clinical diagnostic tests; and

- When the ordering/referring physician has not been assigned a UPIN and does not meet the criteria for using one of the surrogate UPINs, the biller may use the surrogate UPIN "OTH00000" until an individual UPIN is assigned.

  NOTE: This field is required when a service was ordered or referred by a physician.

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

Item 19 - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the contractor is certifying that all the relevant information requirements (including level of subluxation) of the Medicare Benefits Policy Manual, Chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.

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

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

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

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Services," and the Claims Processing Manual, Chapter 16, "Laboratory Services," and the Medicare

General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

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

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

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

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

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

Enter the PIN (or NPI when effective) of the physician who is performing a purchased interpretation of a diagnostic test (see the Medicare Claims Processing Manual, Chapter1, "General Billing Requirements," for additional information). Report the interpreting physician's PIN proceeded by a "PI" indicator (i.e., PI999999).

NOTE: Item 19 can contain up to three conditions per claim. Additional conditions be reported on a separate Form CMS-1500.

Item 20 - Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 be completed. When billing for multiple purchased diagnostic tests, each test on the Form CMS-1500, each test be submitted on a separate claim form. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See Chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). An independent laboratory enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for nonphysician specialties be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

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

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

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

When a physician provides services to a beneficiary residing in a SNF and the services were rendered to a SNF beneficiary outside of the SNF, the physician should enter the Medicare facility provider number of the SNF in item 23.

A substituting physician under a reciprocal billing or locum tenens arrangement (mandated by statute §1842(b)(6)(D) of the Act) may be accommodated using item 23. The billing "absentee" physician's Provider Identification Number (PIN) continue to be reported in item 33 under solo practice arrangements and in item 24*K* under group practice arrangements.

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

Item 24*A* - Enter an 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field.

Return as unprocessable if a date of service extends more than one day and a valid "to" date is not present.

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

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

Item 24*D* - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a NOC code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment be submitted with the claim. This is a required field.

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

Item 24*E* - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

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

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

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

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

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

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

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

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

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

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

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

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

Item 24*J* - Leave blank. Not required by Medicare.

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

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

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

Item 27 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in block 9 and Medigap payment authorization is given in item 13, the provider of service or supplier 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; and
- Drugs and biologicals.

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

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

Item 30 - Leave blank. Not required by Medicare.

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

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 - Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12.

Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms be submitted.

Providers of service (namely physicians) identify the supplier's name, address, ZIP code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in Chapter 1 for disposition of the claim. The carrier processing the foreign

claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name address, or PIN of the location where the order was accepted *must* be entered (DMERC only).

This field is required. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered *must* be entered if other than home.

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

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

If a physician performs a service (s) in a hospital (Place of Service Codes = 21, 22, 23), the physician enter the Medicare provider number, in addition to name and address. When entering the Medicare provider number, precede each number with HSP. Only one provider number per claim may be billed.

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

Enter the UPIN, for the performing provider of service/supplier who is **not** a member of a group practice. This includes the PIN of a billing "absentee" physician is a solo practice.

Enter the group PIN for the performing provider of service/supplier who is a member of a group practice.

Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this field.

10.5 - Place of Service Codes (POS) and Definitions

(Rev. 121, 03-19-04)

- HIPAA
  - The Health Insurance Portability and Accountability Act of 1996 (HIPAA) became effective October 16, 2003, for all covered entities. Medicare is a covered entity under HIPAA.
  - The final rule, "Health Insurance Reform: Standards for Electronic Transactions," published in the "Federal Register", August 17, 2000, adopts the standards to be used under HIPAA and names the implementation guides to be used for these standards. The ASC X12N 837 professional is the standard to be used for transmitting health care claims electronically, and its implementation guide requires the use of POS codes from the National POS code set, currently maintained by CMS.
  - As a covered entity, Medicare must use the POS codes from the National POS code set for processing its electronically submitted claims. Medicare must also recognize as valid POS codes from the POS code set when these codes appear on such a claim.
  - Medicare must recognize and accept POS codes from the National POS code set in terms of HIPAA compliance. Note special considerations for Homeless Shelter (code 04) as well as Indian Health Service (codes 05, 06) and Tribal 638 (codes 07, 08) settings, described below. Where there is no National policy for a given POS code, carriers may work with their carrier medical directors to develop local policy regarding the services payable in a given setting, and this could include creating a crosswalk to an existing setting if desired. However, carriers must pay for the services at either the facility or the nonfacility rate as designated below. In addition, carriers, when developing policy, must ensure that they continue to pay appropriate rates for services rendered in the new setting; if they choose to create a crosswalk from one setting to another, they must crosswalk a facility rate designated code to another facility rate designated code, and a nonfacility rate designated code to another nonfacility rate designated code. For previously issued POS codes for which a crosswalk was mandated, and for which no other National Medicare directive has been issued, carriers may elect to continue to use the crosswalk or develop local policy regarding the services payable in the setting, including another crosswalk, if appropriate. If a carrier develops local policy for these settings, but later receives specific National instructions for these codes, the carriers shall defer to and comply with the newer instructions. (**Note**: While, effective January 1, 2003, codes 03 School, 04 Homeless Shelter, and 20 Urgent Care became part of the National POS code set and were to be crosswalked to 11 Office, this mandate to crosswalk has since been lifted as indicated above).

- The National POS Code Set and Instructions for Using It

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

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

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
07 Tribal 638 Free-Standing Facility A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members who do not require hospitalization . (See instructions below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
08 Tribal 638 Provider-Based Facility A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to tribal members admitted as inpatients or outpatients. (See instructions below.)	Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA
09-10/Unassigned	
11/Office Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.	NF
12/Home Location, other than a hospital or other facility, where the patient receives care in a private residence.	NF
13/Assisted Living Facility Congregate residential facility with self-contained living units providing assessment of each resident’s needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.	NF

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
*14/Group Home (Description Revised Effective April 1, 2004) A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (e.g., medication administration).	NF
15/Mobile Unit A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.	NF
16-19/Unassigned	--
20/Urgent Care Facility Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.	NF
21/Inpatient Hospital A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.	F
22/Outpatient Hospital A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.	F
23/Emergency Room-Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	F

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

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
33/Custodial Care Facility A facility which provides room, board and other personal assistance services, generally on a longterm basis, and which does not include a medical component.	NF
34/Hospice A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.	F
35-40 Unassigned	--
41/Ambulance—Land A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
42/Ambulance—Air or Water An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.	F
43-48/Unassigned	--
49/Independent Clinic A location, not part of a hospital and not described by any other Place of Service code, that is organized and operated to provide preventive, diagnostic, therapeutic, rehabilitative, or palliative services to outpatients only.	NF
50/Federally Qualified Health Center A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.	NF

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
51/Inpatient Psychiatric Facility A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.	F
52/Psychiatric Facility-Partial Hospitalization A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.	F
53/Community Mental Health Center A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.	F
54/Intermediate Care Facility/Mentally Retarded A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.	NF
55/Residential Substance Abuse Treatment Facility A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.	NF

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
56/Psychiatric Residential Treatment Center A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.	F
57/Non-residential Substance Abuse Treatment Facility A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.	NF
58-59/Unassigned	--
60/Mass Immunization Center A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.	NF
61/Comprehensive Inpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.	F
62/Comprehensive Outpatient Rehabilitation Facility A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.	NF
63-64/Unassigned	--

POS Code/Name Description *= New or Revised code or code not previously implemented by Medicare	Payment Rate Facility=F Nonfacility=NF
65/End-Stage Renal Disease Treatment Facility A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.	NF
66-70/Unassigned	--
71/State or Local Public Health Clinic A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general directionof a physician.	NF
72/Rural Health Clinic A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.	NF
73-80/Unassigned	
81/Independent Laboratory A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.	NF
82-98/Unassigned	
99/Other Place of Service Other place of service not identified above.	NF

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

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

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

  Medicare does not currently use the POS codes designated for these settings. Follow the instructions you have received regarding how to process claims for services rendered in IHS and Tribal 638 settings. If you receive claims with these codes, you must initially accept them in terms of HIPAA compliance. However, follow your "return as unprocessable" procedures after this initial compliance

check. Follow your "return as unprocessable" procedures when you receive paper claims with these codes. (Note that while these codes became part of the National POS code set effective January 1, 2003, Medicare contractors received instructions regarding how to process claims with these codes effective October 1, 2003, so that Medicare could be HIPAA compliant by October 16, 2003).

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

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

- **Paper Claims**

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

10.6 - Carrier Instructions for Place of Service (POS) Codes

(Rev. 1, 10-01-03)

B3-4020.3

If the physician bills for lab services performed in his/her office, the 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 a hospital inpatient, it uses the code for "Hospital Inpatient".

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, on the Form CMS-1500, if a claim contains more than one POS (other han Home – 12), 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. 108, 02-27-04)

Medicare carriers must use the following table to assign the proper TOS. Some procedures may have more than one applicable TOS. For claims received on or after April 3, 1995, CWF will produce alerts on codes with incorrect TOS designations. Effective July 3, 1995, CWF is rejecting codes with incorrect TOS designations.

The only exceptions to this table are:

- Surgical services billed with the ASC facility service modifier SG must be reported as TOS F. The indicator F does not appear on the TOS table because its use is dependent upon the use of the SG modifier.

- 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 Medicare Claims Processing Manual, Chapter 12, "Physician/Practitioner Billing," for instructions on when assistant-at-surgery is allowable.)

- Psychiatric treatment services that are subject to the outpatient mental health treatment limitation should be reported with TOS T.

- 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 carrier should not submit TOS H to CWF at this time.

- When these specific transfusion medicine codes appear on the claim (86880, 86885, 86886, 86900, 86903, 86904, 86905, and 86906 that also contains a blood product (P9010-P9022)), the transfusion medicine codes are paid under reasonable charge. When these services are to be paid under reasonable charge, use TOS 1. When paid under reasonable charge, tests are paid at 80 percent. Coinsurance and deductible also 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 following table 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

HCPCS RANGE and Applicable Type of Service (TOS) Code
B3-4020.4, Transmittal 1783

First Code	Last Code	TOS
A0021	A0999	D
A4206	A4213	S
A4214	A4214	P
A4215	A4215	S
A4216	A4217	1,P, L
A4220	A4232	P
A4244	A4247	S, L
A4248	A4248	L
A4250	A4250	9
A4253	A4253	P

First Code	Last Code	TOS
A4254	A4254	A, P, R
A4255	A4259	P
A4260	A4270	9
A4280	A4280	P
A4281	A4290	9
A4300	A4301	S
A4305	A4306	9
A4310	A4359	P
A4360	A4360	9
A4361	A4434	P
A4450	A4452	P, L, S
A4454	A4455	P
A4458	A4458	9
A4460	A4462	S
A4464	A4464	P
A4465	A4465	9
A4470	A4510	P
A4521	A4554	9
A4556	A4572	P
A4575	A4606	9
A4608	A4613	P
A4614	A4614	9
A4615	A4617	P
A4618	A4618	A, P, R

First Code	Last Code	TOS
A4619	A4626	P
A4627	A4627	9
A4628	A4628	A, P, R
A4629	A4629	P
A4630	A4633	A, P, R
A4634	A4634	9
A4635	A4637	A, P, R
A4638	A4638	P
A4639	A4640	A, P, R
A4641	A4647	4
A4649	A4649	9
A4650	A4931	L
A4932	A4932	9
A5051	A5200	P
A5500	A5511	J
A6000	A6000	P
A6010	A6024	S
A6025	A6025	9
A6154	A6248	S
A6250	A6250	S, L
A6251	A6259	S
A6260	A6260	S, L
A6261	A6512	S

First Code	Last Code	TOS
A6550	A6551	P
A7000	A7002	A, P, R
A7003	A7004	P
A7005	A7006	A, P, R
A7007	A7008	P
A7009	A7009	A, P, R
A7010	A7011	P
A7012	A7012	A, P, R
A7013	A7013	P
A7014	A7017	A, P, R
A7018	A7020	P
A7025	A7039	A, P, R
A7042	A7043	P
A7044	A7044	A, P, R
A7046	A7526	P
A9150	A9300	9
A9500	A9522	4
A9523	A9523	6
A9524	A9534	4
A9600	A9699	6
A9700	A9999	9
B4034	B5200	E
B9000	B9006	A, P, R
B9998	B9999	E

First Code	Last Code	TOS
C1000	C1008	9,S
C1009	C1009	9
C1010	C1011	0
C1012	C1014	9
C1015	C1018	0
C1019	C1019	9
C1020	C1021	0
C1022	C1022	9
C1024	C1043	9,S
C1045	C1045	4
C1047	C1048	9,S
C1050	C1050	9
C1051	C1057	9, S
C1058	C1058	4
C1059	C1059	9
C1060	C1063	9, S
C1064	C1066	4
C1067	C1078	9, S
C1079	*C1080*	*4*
C1081	*C1081*	*6*
C1082	*C1082*	*4*
C1083	*C1083*	*6*
C1084	C1086	1,P
C1087	C1087	4

First Code	Last Code	TOS
C1088	C1088	9
C1089	C1099	4
C1100	C1121	9,S
C1122	C1122	4
C1123	C1154	9,S
C1155	C1155	9
C1156	C1163	9,S
C1164	C1164	9
C1166	C1167	1,P
C1170	C1177	9,S
C1178	C1178	1,P
C1179	C1184	9,S
C1188	C1202	4
C1203	C1203	9
C1205	C1205	4
C1207	C1300	9
C1302	C1304	9,S
C1305	C1305	9
C1306	C1324	9,S
C1325	C1325	4
C1326	C1337	9,S
C1348	C1350	4
C1351	C1359	9,S
C1360	C1360	9

First Code	Last Code	TOS
C1361	C1773	9,S
C1774	C1774	9
C1775	C1775	4
C1776	C1799	9,S
C1800	C1806	4
C1810	C2631	9,S
C2632	C2632	9
C2633	C8891	9,S
C8900	C8920	4
C9000	C9010	1
C9011	C9011	9,S
C9012	C9020	1
C9100	C9103	4
C9104	C9106	1
C9107	C9107	9,S
C9108	C9109	9
C9110	C9110	9,S
C9111	C9119	9
C9120	C9121	1, P
C9123	C9123	9,S
C9200	C9209	9
C9211	C9212	9,G
C9500	C9503	9
C9701	C9701	9, S

First Code	Last Code	TOS
C9703	C9703	9
C9704	C9704	2
C9708	C9708	4
C9711	C9711	9
D0120	D0180	1
D0210	D0350	4
D0415	D0999	5
D1110	D1351	1
D1510	D1525	9
D1550	D3120	1
D3220	D3221	2
D3230	D3348	1
D3351	D3920	2
D3950	D3999	1
D4210	D4276	2
D4320	D4999	1
D5110	D5281	9
D5410	D5761	1
D5810	D5999	9
D6010	D6050	2
D6053	D6079	9
D6080	D6080	2
D6090	D6999	9
D7110	D7999	2

First Code	Last Code	TOS
D8010	D9110	1
D9210	D9248	7
D9310	D9310	3
D9410	D9450	1
D9610	D9630	9
D9910	D9999	1
E0100	E0144	A, P, R
E0145	E0146	R
E0147	E0164	A, P, R
E0165	E0166	R
E0167	E0168	A, P, R
E0169	E0169	R
E0175	E0179	A, P, R
E0180	E0182	R
E0184	E0185	A, P, R
E0186	E0187	R
E0188	E0189	A, P, R
E0190	E0190	9
E0191	E0192	A, P, R
E0193	E0196	R
E0197	E0200	A, P, R
E0202	E0202	R
E0203	E0203	9
E0205	E0205	A, P, R

First Code	Last Code	TOS
E0210	E0210	A, P, R, L
E0215	E0230	A, P, R
E0231	E0231	R
E0232	E0232	P
E0235	E0236	R
E0238	E0239	A, P, R
E0240	E0240	9
E0241	E0249	A, P, R
E0250	E0270	R
E0271	E0276	A, P, R
E0277	E0277	R
E0280	E0280	A, P, R
E0290	E0298	R
E0300	E0300	A, P, R
E0301	E0305	R
E0310	E0315	A, P, R
E0316	E0316	R
E0325	E0326	A, P, R
E0350	E0352	9
E0370	E0373	A, P, R
E0424	E0440	R
E0441	E0444	P
E0445	E0445	9
E0450	E0455	R

First Code	Last Code	TOS
E0457	E0457	A, P, R
E0459	E0480	R
E0481	E0481	A, P, R
E0482	E0483	R
E0484	E0484	A, P, R
E0500	E0550	R
E0555	E0555	P, R
E0560	E0562	A, P, R
E0565	E0570	R
E0571	E0574	A, P, R
E0575	E0575	R
E0580	E0580	P, R
E0585	E0585	R
E0590	E0590	9
E0600	E0601	R
E0602	E0604	9
E0605	E0605	A, P, R
E0606	E0606	R
E0607	E0607	A, P, R
E0608	E0608	R
E0609	E0615	A, P, R
E0616	E0616	9
E0617	E0617	9,R
E0618	E0619	R

First Code	Last Code	TOS
E0620	E0629	A, P, R
E0630	E0636	R
E0637	E0673	A, P, R
E0675	E0675	R
E0690	E0740	A, P, R
E0744	E0745	R
E0746	E0748	A, P, R
E0749	E0749	9
E0751	E0754	P
E0755	E0755	A, P, R
E0756	E0759	P
E0760	E0760	A, P, R
E0761	E0761	9
E0765	E0765	A, P
E0776	E0776	A, P, R, E
E0779	E0780	A, P, R
E0781	E0781	9, R
E0782	E0783	A, P, R
E0784	E0784	R
E0785	E0785	P
E0786	E0786	9
E0791	E0791	R
E0830	E0830	P
E0840	E0900	A, P, R

First Code	Last Code	TOS
E0910	E0941	R
E0942	E0945	A, P, R
E0946	E0946	R
E0947	E0957	A, P, R
E0958	E0958	R
E0959	E0967	A, P, R
E0968	E0968	R
E0969	E0982	A, P, R
E0983	E0983	R
E0984	E1030	A, P, R
E1031	E1060	R
E1065	E1069	A, P, R
E1070	*E1160*	*R*
E1161	*E1161*	*A, P, R*
E1170	*E1200*	*R*
E1210	E1213	A, P, R
E1220	E1220	P
E1221	E1225	R
E1226	E1227	A, P, R
E1228	E1228	R
E1230	E1230	A, P, R
E1231	*E1238*	*A, P, R*
E1240	*E1295*	*R*
E1296	E1310	A, P, R

First Code	Last Code	TOS
E1340	E1340	9
E1353	E1355	R
E1372	E1372	A, P, R
E1375	E1391	R
E1399	E1399	A, P, R
E1400	E1406	R
E1500	E1699	L
E1700	E1700	A, P, R
E1701	E1702	P
E1800	E1801	P, R
E1802	E1802	R
E1805	E1840	P, R
E1900	E1902	A, P, R
E2000	E2000	R
E2100	*E2101*	*A, P, R*
E2120	*E2120*	*R*
E2201	*E2399*	*A, P ,R*
E2402	E2402	R
E2500	E2599	A, P, R
G0001	G0001	5
G0002	G0002	2
G0004	G0007	5
G0008	G0009	V
G0010	G0010	1

First Code	Last Code	TOS
G0015	G0016	5
G0022	G0024	1
G0025	G0025	S
G0026	G0027	5
G0030	G0050	4
G0101	G0102	1
G0103	G0103	5
G0104	G0105	2
G0106	G0106	4
G0107	G0107	5
G0108	G0113	1
G0114	G0114	3
G0115	G0116	T, 1
G0117	G0118	Q
G0120	G0120	4
G0121	G0121	2
G0122	G0122	4
G0123	G0124	5
G0125	G0126	4
G0127	G0127	2
G0128	G0128	1
G0129	G0129	U
G0130	G0132	4
G0141	G0148	5

First Code	Last Code	TOS
G0151	G0156	1
G0159	G0160	2
G0161	G0161	6
G0163	G0165	4
G0166	G0168	1
G0169	G0169	W, 1
G0170	G0171	2
G0172	G0172	U
G0173	G0174	2
G0175	G0175	1
G0176	G0177	U
G0178	G0178	6
G0179	G0182	1
G0184	G0187	2
G0188	G0188	4
G0190	G0203	1
G0204	G0236	4
G0237	G0241	1
G0242	G0243	2
G0244	G0247	1
G0248	G0249	5
G0250	G0250	1
G0251	G0255	4
G0256	G0256	2

First Code	Last Code	TOS
G0257	G0260	1
G0261	G0261	2
G0262	G0262	4
G0263	G0264	1
G0265	G0267	5
G0268	G0272	1
G0273	G0274	6
G0275	G0278	2
G0279	G0283	1,U, W
G0288	G0288	1
G0289	G0291	2
G0292	G0292	1
G0293	G0294	2
G0295	G0295	1,U, W
G0296	G0296	4
G0297	G0300	2
G0301	G0305	1
G0306	G0307	5
G0308	*G0327*	*1*
G0328	*G0328*	*5*
G3001	*G9016*	*1*
H0001	H2037	9
J0120	J0210	P, 1
J0270	J0270	1

First Code	Last Code	TOS
J0215	J0215	1,G
J0256	J0256	1,P
J0270	J0275	1
J0280	J0592	P, 1
J0595	J0595	1
J0600	J1642	1,P
J1644	J1644	P, 1, L
J1645	J1820	P, 1
J1825	J1830	1
J1835	J2916	P, 1
J2920	J2930	G, 1
J2940	J7199	P, 1
J7300	J7303	9
J7308	J7308	1
J7310	J7310	9
J7315	J7320	1
J7330	J7330	P, 1
J7340	J7340	1
J7342	J7342	S
J7350	J7350	1,S
J7500	J7599	G, 1
J7608	J8521	P, 1
J8530	J8530	P, G, 1
J8560	J8600	P, 1

First Code	Last Code	TOS
J8610	J8610	P, G, 1
J8700	J9212	P, 1
J9213	J9216	G
J9217	J9999	P, 1
K0001	K0004	R
K0005	K0005	A, P, R
K0006	K0007	R
K0008	K0008	P
K0009	K0012	A, P, R
K0013	K0013	P
K0014	K0100	A, P, R
K0101	K0101	R
K0102	K0108	A, P, R
K0109	K0113	P
K0114	K0116	A, P, R
K0119	K0123	G
K0137	K0169	P
K0170	K0171	A, P, R
K0172	K0173	P
K0174	K0174	A, P, R
K0175	K0176	P
K0177	K0177	A, P, R
K0178	K0178	P
K0179	K0181	A, P, R

First Code	Last Code	TOS
K0182	K0182	P
K0183	K0192	A, P, R
K0193	K0195	R
K0268	K0270	A, P, R
K0277	K0283	P
K0284	K0284	A, P, R
K0400	K0400	P
K0401	K0401	J
K0407	K0411	P
K0412	K0412	G
K0415	K0416	1
K0417	K0417	A, P, R
K0418	K0418	G
K0419	K0451	P
K0452	K0452	A, P, R
K0455	K0456	R
K0457	K0459	A, P, R
K0460	K0461	P, R
K0462	K0462	9
K0501	K0501	R
K0503	K0529	P
K0530	K0531	A, P, R
K0532	K0534	R
K0535	K0537	S

First Code	Last Code	TOS
K0538	K0538	R
K0539	K0540	P
K0541	K0547	A, P, R
K0548	K0548	1, P
K0549	K0550	R
K0551	K0551	A, P, R
K0552	K0597	P
K0600	K0608	A, P, R
K0609	K0609	P
K0610	K0614	L
K0615	K0617	A, P, R
K0618	K0619	P
K0620	K0626	S
L0100	L3963	P
L3964	L3974	A, P, R
L3980	L8100	P
L8110	L8120	P, S
L8130	L9900	P
M0064	M0300	1
M0301	M0301	2
M0302	M0302	5
P2028	P7001	5
P9010	P9010	0
P9011	P9012	9

First Code	Last Code	TOS
P9016	P9016	0
P9017	P9020	9
P9021	P9022	0
P9023	P9037	9
P9038	P9040	0
P9041	P9050	9
P9051	P9051	0
P9052	P9053	9
P9054	P9054	0
P9055	P9055	9
P9056	P9058	0
P9059	P9060	9
P9603	P9615	5
Q0034	Q0034	1
Q0035	Q0035	5
Q0068	Q0068	9
Q0081	Q0081	1
Q0082	Q0082	9
Q0083	Q0085	1
Q0086	Q0086	9
Q0091	Q0091	1
Q0092	Q0092	4
Q0111	Q0115	5
Q0132	Q0136	9

First Code	Last Code	TOS
Q0137	Q0137	1,L
Q0144	Q0144	1
Q0156	Q0161	P, 1
Q0163	Q0181	1
Q0182	Q0185	S
Q0186	Q0186	1
Q0187	Q0187	P, 1
Q0188	Q0188	9
Q1001	Q1005	F
Q2001	Q2018	1,P
Q2019	Q2019	1,G
Q2020	Q2022	1,P
Q3000	Q3000	4
Q3001	Q3001	1
Q3002	Q3012	4
Q3013	Q3014	9
Q3017	Q3020	D
Q3025	Q3030	P, 1
Q3031	Q4051	S
Q4052	Q4053	1,P
Q4054	Q4055	1,L
Q4075	Q4077	P, 1
Q4078	Q4078	4
Q9920	Q9940	L, 1

First Code	Last Code	TOS
R0070	R0075	4
R0076	R0076	5
S0009	S0011	P, 1
S0012	S0012	1
S0014	S0087	P, 1
S0088	S0088	9
S0090	S0090	P, 1
S0091	S0093	9
S0096	S0098	1,P
S0104	S0104	1
S0106	S0108	9
S0112	S0112	1
S0114	S0115	9
S0122	S0135	1,P
S0136	S0157	9
S0170	S0170	1, P
S0171	S0178	9
S0179	S0179	1, P
S0181	S0187	9
S0189	S0189	1, P
S0190	S0201	9
S0206	S0206	2
S0207	S0207	9
S0208	S0215	D

First Code	Last Code	TOS
S0220	S0400	9
S0500	S0592	Q
S0601	S0800	9
S0810	S0810	2,9
S0812	S0812	Q
S0820	S0830	9
S1001	S1002	P
S1015	S1016	9
S1025	S1025	1
S1030	S1030	P, R
S1031	S1031	A, P, R
S1040	S1040	P
S2050	S2053	2,9
S2054	S2061	9
S2065	S2065	2
S2070	S2109	9
S2112	S2112	2
S2113	S2371	9
S2400	S2404	2
S2405	S2405	9
S2409	S2409	2
S2411	S3708	9
S3818	S3819	5
S3820	S4980	9

First Code	Last Code	TOS
S4981	S4981	2
S4989	S8001	9
S8002	S8003	1
S8004	S8035	9
S8037	S8037	4
S8040	S8210	9
S8260	S8260	P
S8262	S8265	9
S8300	S8300	S
S8400	S8433	9
S8450	S8452	P
S8460	S8470	9
S8490	S8490	S
S8945	S9528	9
S9529	S9529	5
S9533	S9590	9
S9800	S9800	1
S9802	T1014	9
T1015	T1015	1
T1016	T5999	9
V2020	V2615	Q
V2623	V2629	P
V2630	V2799	Q
V5008	V5299	K

First Code	Last Code	TOS
V5336	V5336	1
V5362	V5364	1,W
00100	00103	7
00104	00104	T, 7
00120	00860	7
00862	00862	N, 7
00864	01999	7
10021	11012	2
11040	11044	2, U, W
11055	20975	2
20979	20979	6
20982	29085	2
29086	29590	2,U, W
29700	36410	2
36415	36415	5
36416	36416	1
36420	36510	2
36511	36516	1
36520	38200	2
38204	38204	1
38205	38206	2
38207	38209	1
38210	38210	2
38211	38215	5

First Code	Last Code	TOS
38220	38241	2
38242	38242	5
38300	50290	2
50300	50320	N
50340	50546	2
50547	50547	N
50548	55845	2
55859	55859	6
55860	62230	2
62252	62252	1
62256	64530	2
64550	64550	2, U, W
64553	69990	2
70010	75893	4
75894	75896	6
75898	75898	4
75900	75968	6
75970	75970	4
75978	75989	6
75992	76082	4
76083	76085	1
76086	76091	4
76092	76092	B, C, 1
76093	76934	4

First Code	Last Code	TOS
76936	76936	6
76937	76937	4
76938	76938	6
76940	76940	4
76941	76942	6
76945	76945	4
76946	76965	6
76970	76999	4
77261	77799	6
78000	78264	4
78267	78268	5
78270	78999	4
79000	79999	6
80048	80440	5
80500	80502	3
81000	86870	5
86880	86886	1, 5
86890	86891	5
86900	86900	1, 5
86901	86901	5
86903	86911	1, 5
86915	88319	5
88321	88332	3
88342	89399	5

First Code	Last Code	TOS
90281	90648	1
90655	90660	V
90665	90665	1
90669	90669	V
90675	90727	1
90732	90732	V
90733	90802	1
90804	90899	T, 1
90901	90911	U, W, 1
90918	90921	M
90922	90999	1
91000	91065	5
91100	91105	2
91110	91110	4
91122	91122	2
91123	91123	1
91132	91133	5
91299	91299	2
92002	92014	1
92015	92015	Q
92018	92060	1
92065	92396	Q
92499	92504	1
92506	92508	W, 1, U

First Code	Last Code	TOS
92510	92510	K, U, W
92511	92520	1
92525	92526	U, W, 1
92531	92548	1
92551	92596	K
92597	92598	W, 1
92599	92616	1
92617	92617	2
92700	92971	1
92973	92977	2
92978	92979	4
92980	92998	2
93000	93350	5
93501	93545	2
93555	93556	4
93561	93662	2
93668	93668	9
93701	94621	5
94640	94668	1
94680	94799	5
95004	95250	1
95805	95830	5
95831	95852	U, W, 5
95857	95870	W, 5

First Code	Last Code	TOS
95872	95927	5
95930	95930	Q
95933	95962	5
95965	95967	4
95970	95975	5
95990	95991	1
95999	95999	5
96000	96003	1,W
96004	96100	1
96105	96115	U, W, 5
96117	96155	5
96400	96567	1
96570	96571	2
96900	96913	1
96920	96922	2
96999	96999	1
97001	97799	1, U, W
97802	97804	9
98925	98943	1
99000	99002	9
99024	99058	1
99070	99071	9
99075	99091	1
99100	99142	7

First Code	Last Code	TOS
99170	99170	5
99172	99173	Q
99175	99239	1
99241	99275	3
99281	99440	1
99450	99456	9
99499	99539	1
99551	99569	9
99600	99600	1
99601	99602	9
0001T	0002T	2
0003T	0003T	5
0005T	0009T	2
0010T	0010T	5
0012T	0021T	2
0023T	0023T	5
0024T	0024T	2
0025T	0026T	9
0027T	0027T	2
0028T	0028T	4
0029T	0029T	9
0030T	0031T	5
0032T	0039T	2
0040T	0041T	5

First Code	Last Code	TOS
0042T	0043T	4
0044T	0045T	9
0046T	0057T	2
0058T	0061T	5
0001F	0011F	1

10.8 - Requirements for Specialty Codes

(Rev. 1, 10-01-03)

B3- 2207

Specialty codes are self-designated and they describe the kind of medicine physicians, nonphysician practitioners or other healthcare providers/suppliers practice. Appropriate use of specialty codes prevents inappropriate suspension and improves the quality of utilization data.

A physician, nonphysician practitioner, or other healthcare provider or supplier will submit a specialty code change via the Form CMS-855 application. Carriers and DMERCs update the specialty code that is submitted to CWF on the Part B Claim Record and the one used for prepayment and post payment Medical Review. This should also be consistent with the carrier and DMERCs UPIN files and provider files. Contractors must follow the most cost-effective method for updating specialty codes. If it is costly to maintain old specialties for dates of service prior to the update, contractors use the new specialty codes for all claims even if it results in higher payments to the physician.

Carriers and DMERCs must not add any specialty codes to the list. They send all requests for expansion of the list to their Regional Office (RO). The RO will forward the list to Central Office (CO). CO will consider the following:

- Whether the requestor has the authority to bill independently;
- The reason or purpose for the code and if a current code would suffice;
- Whether they are recognized by another organization, such as the American Board of Medical Specialties; and
- Whether the specialty treats a significant volume of the Medicare population.

All physicians that have a UPIN must have a specialty code other than specialty 70, single or multi-specialty "Clinic" or "Group Practice". Contractors must contact physicians who are listed as specialty 70 and obtain a valid specialty.

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

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 Therapy
13	Neurology
14	Neurosurgery
15	Available

Code	Physician Specialty
16	Obstetrics/Gynecology
17	Available
18	Ophthalmology
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
21	Available
22	Pathology
23	Available
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
27	Available
28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
31	Available
32	Anesthesiologist Assistants
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology

Code	Physician Specialty
40	Hand Surgery
41	Optometry
44	Infectious Disease
46	Endocrinology
48	Podiatry
66	Rheumatology
70	Single or Multispecialty Clinic or Group Practice
72	Pain Management
73	Mass Immunization Roster Biller
74	Radiation Therapy Center
75	Slide Preparation Facilities
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

Code	Physician Specialty
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty

10.8.3 - Nonphysician Practitioner, Supplier, and Provider Specialty Codes

B3-2207.1

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

Code	Nonphysician Practitioner/Supplier/Provider Specialty
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.
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.

Code	Nonphysician Practitioner/Supplier/Provider Specialty
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	Clinical 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 Supplier/Provider
89	Certified Clinical Nurse Specialist

Code	Nonphysician Practitioner/Supplier/Provider Specialty
95	Available
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

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 - Obtaining Copies of the Form CMS-1500

(Rev. 1, 10-01-03)

B3-3002

Carriers, physicians, and suppliers are responsible for purchasing their own Form CMS-1500 forms. This form can be bought in single, multi-part snap-out sets or in continuous pin-feed format. Medicare accepts any version. Forms can be obtained from local printers or printed in-house as long as it follows the CMS approved specifications developed by the American Medical Association.

20 – Paper Claims

(Rev. 145, 04-23-04)

B3-3002, B3-4020, B4-2010, B3-3002, B3-3003, B3-3042, B3-7563

The Form CMS-1500 (Health Insurance Claim Form) is the prescribed form for billing of Medicare, Part B covered services by noninstitutional providers and suppliers. The Form CMS-1500 can be used for both assigned and non-assigned claims, and is sometimes referred to as the AMA form. It can be purchased in any version required i.e., single sheet, snap-out, continuous. Forms can be purchased from the U.S. Government Printing Office (call 202-512-1800). An electronic version is available at http://www.cms.hhs.gov/providers/edi/edi5.asp.

Form CMS-1490S (Patient's Request for Medicare Payment)

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 a MSP claim. Assume this is the case if the beneficiary files a 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.)