Medicare Claims Processing Manual
Chapter 26 - Completing and Processing Form CMS-1500 Data Set

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(Rev. 2226, 05-20-11)
(Rev. 2261, 07-29-11)
(Rev. 2375, 12-22-11)

10 - Health Insurance Claim Form CMS-1500

(Rev. 2162, Issued: 02-22-11, Effective: 03-21-11, Implementation: 03-21-11)

The current version of the form is Form CMS-1500 (08/05) and is approved under the OMB collection 0938-0999. 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, whether or not the claims are assigned.

Carriers, physicians, and suppliers are responsible for purchasing their own Form CMS-1500 forms. Forms can be obtained from printers or printed in-house as long as they follow the CMS approved specifications (see section 30) developed by the American Medical Association. Photocopies of the Form CMS-1500 are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the Form CMS-1500 for processing. To purchase forms from the U.S. Government Printing Office, call (202) 512-1800.

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 TRICARE Program 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 or A/B MACs 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 or A/B MACs 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 to complete 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 or A/B MACs 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 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)	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)	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. 1420; Issued: 01-25-08; Effective: 10-01-07; Implementation: 02-01-08)

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, 6, 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 *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 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 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 - 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 through the Medigap claim-based crossover process, the participating provider of service or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d.
A Medicare participating provider or supplier shall **only** enter the COBA Medigap claim-based ID within item 9d when seeking to have the beneficiary's claim crossed over to a Medigap insurer. If a participating provider or supplier enters the PAYERID or the Medigap insurer program or its plan name within item 9d, the Medicare Part B contractor or Durable Medical Equipment Medicare Administrative Contractor (DMAC) will be unable to forward the claim information to the Medigap insurer prior to October 1, 2007, or to the Coordination of Benefits Contractor (COBC) for transfer to the Medicare insurer on or after October 1, 2007. (See chapter 28 §70.6.4 for more information concerning the COBA Medigap claim-based crossover process.)
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. (See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3.)

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

(Rev. 1369; Issued: 11-02-07; Effective: 04-01-08; Implementation: 04-07-08)

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 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, "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 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. 2261, Issued: 07-29-11, Effective: CWF/FISS: 07-01-11, (Analysis, Design and Development) and 01-01-12 (Additional Development, Testing and Implementation) For MCS: 07-01- 11 (Analysis, Design Development and Partial Implementation) and 01-01-12 (Testing and Full Implementation) Implementation: 01-03-12

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

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 1835of 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;

Item 17a – Leave blank.

Item 17b Form CMS-1500 – Enter the NPI of the referring/ordering physician listed in item 17. All physicians 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.

For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the NPI of an ordering/referring/attending/certifying physician or non-physician practitioner is not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17b, and for the identification of the supervisor, see item 24J of this section.

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 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 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 an 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 From Independent Labs, Physicians and Providers," 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 3113 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 identifiers submitted on the Form CMS-1500 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 carriers or A/B MACs 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 an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall 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 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 Form CMS-1500.

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 location, 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 hospital inpatient, use the “inpatient hospital” code.

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 Form CMS-1500 has the ability 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 an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

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

If a situation arises where two or more diagnoses are required for a procedure code (e.g., pap smears), the 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 B/MAC 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, **e**nter 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, 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 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 Form CMS-1500 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 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 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 Form CMS-1500 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.

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 - Effective May 23, 2008, Item 33b is not to be reported.

10.5 - Place of Service Codes (POS) and Definitions

(Rev. 1869; Issued: 12-11-10; Effective/Implementation Date: 03-11-10)

- 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).

- 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. This code set has changed to include a new code, 17 Walk-in Retail Health Clinic. The effective date of this code is no later than May 1, 2010. The health care industry is permitted to use this code from the date it is posted on the Medicare POS code set Web page, which is expected to be some months ahead of this final effective date.

It should be noted that, while some entities in the industry may elect to use 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 code 17, even if its presence on a claim is contrary to these billing instructions.

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.	NF
18-19 Unassigned	--
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
23 Emergency Room-Hospital A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.	F

POS Code and Name (effective date) Description	**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
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
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

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
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 (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,	F

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
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.	
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

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=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	--
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	NF

POS Code and Name (effective date) Description	**Payment Rate** Facility=F Nonfacility=NF
Other place of service not identified above.	

- **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.

- **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.)

- **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. 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 than 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. 2375, Issued: 12-22-11, Effective: 01-01-12, Implementation: 01-03-12)

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. All future updates will be submitted via a Recurring Update Notification.

The only exceptions to this table 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.)

- 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.

- 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 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

First Code	Last Code	TOS
A0021	A0999	D
A4206	A4213	S
A4214	A4214	P
A4215	A4215	L, S
A4216	A4218	1,L,P
A4220	A4236	P
A4244	A4247	L,S
A4248	A4248	L
A4250	A4250	9
A4252	A4253	P
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

First Code	Last Code	TOS
A4360	A4360	9
A4361	A4434	P
A4450	A4452	L,P,S
A4454	A4456	P
A4458	A4458	9
A4460	A4463	S
A4464	A4464	P
A4465	A4466	9
A4470	A4510	P
A4520	A4554	9
A4556	A4565	P
A4566	A4566	9
A4570	A4572	P
A4575	A4590	9
A4595	A4605	P
A4606	A4606	9
A4608	A4613	P
A4614	A4614	9
A4615	A4617	P
A4618	A4618	A,P,R
A4619	A4626	P
A4627	A4627	9
A4628	A4628	A,P,R
A4629	A4629	P

First Code	Last Code	TOS
A4630	A4633	A,P,R
A4634	A4634	9
A4635	A4637	A,P,R
A4638	A4638	P
A4639	A4640	A,P,R
A4641	A4647	4
A4648	A4648	9,S
A4649	A4649	9
A4650	A4650	9,S
A4651	A4931	L
A4932	A4932	9
A5051	A5200	P
A5500	A5513	J
A6000	A6000	P
A6010	A6024	S
A6025	A6025	9
A6154	A6214	S
A6215	A6216	L,S
A6217	A6248	S
A6250	A6250	L,S
A6251	A6259	S
A6260	A6260	L,S
A6261	A6266	S
A6402	A6402	L,S

First Code	Last Code	TOS
A6403	A6412	S
A6413	A6413	P
A6421	A6512	P,S
A6513	A6530	P
A6531	A6532	P,S
A6533	A6544	P
A6545	A6545	P,S
A6549	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	A7018	P
A7020	A7020	A,P,R
A7025	A7039	A,P,R
A7040	A7043	P
A7044	A7045	A,P,R
A7046	A7527	P
A8000	A8004	A,P,R

First Code	Last Code	TOS
A9150	*A9272*	9
A9273	A9273	A,P,R
A9274	A9280	9
A9281	A9281	A,P,R
A9282	A9283	9
A9284	A9284	A,P,R
A9300	A9300	9
A9500	A9516	4
A9517	A9517	6
A9518	A9522	4
A9523	A9523	6
A9524	A9529	4
A9530	A9530	6
A9531	A9531	4
A9532	A9532	6
A9533	A9533	4
A9534	A9534	6
A9535	A9542	4
A9543	A9543	6
A9544	A9544	4
A9545	A9545	6
A9546	A9562	4
A9563	A9564	6
A9565	A9580	4

First Code	Last Code	TOS
A9581	A9581	1,P
A9582	*A9585*	4
A9600	A9605	6
A9698	A9698	4
A9699	A9699	6
A9700	A9999	9
B4034	B5200	E
B9000	B9006	A,P,R
B9998	B9999	E
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

First Code	Last Code	TOS
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
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

First Code	Last Code	TOS
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
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	C2633	9,S
C2634	C2636	9
C2637	C2637	4
C2638	C2638	6
C2639	C2643	4
C2676	C2676	9,S
C2698	C8936	4
C9113	*C9113*	9

First Code	Last Code	TOS
C9121	C9121	1,P
C9248	*C9248*	1
C9250	*C9272*	9
C9273	*C9273*	*1*
C9274	*C9274*	*9*
C9275	*C9275*	*4*
C9276	*C9278*	*9*
C9279	*C9287*	*1*
C9352	*C9367*	*9*
C9399	C9399	1
C9406	*C9406*	4
C9724	*C9724*	2
C9725	*C9726*	6
C9727	*C9732*	2
C9800	*C9899*	*1*
D0120	D0180	1
D0210	D0363	4
D0415	D0999	5
D1110	D1351	1
D1352	D1525	9
D1550	D2710	1
D2712	D2712	9
D2720	D2792	1
D2794	D2794	9

First Code	Last Code	TOS
D2799	D2910	1
D2915	D2915	9
D2920	D2933	1
D2934	D2934	9
D2940	D2970	1
D2971	D2975	9
D2980	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	D7282	2
D7283	D7283	9
D7285	D7999	2
D8010	D9110	1

First Code	Last Code	TOS
D9120	D9120	2
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
E0170	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,L,P,R
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	E0326	A,P,R
E0328	E0329	R
E0350	E0352	9
E0370	E0373	A,P,R
E0424	E0431	R
E0433	E0433	A,P,R
E0434	E0440	R
E0441	E0444	P
E0445	E0446	9

First Code	Last Code	TOS
E0450	E0455	R
E0457	E0457	A,P,R
E0459	E0480	R
E0481	E0481	A,P,R
E0482	E0483	R
E0484	E0484	A,P,R
E0485	E0486	P
E0487	E0487	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

First Code	Last Code	TOS
E0616	E0616	9
E0617	E0617	9,R
E0618	E0619	R
E0620	E0629	A,P,R
E0630	E0636	R
E0637	E0638	A,P,R
E0639	E0640	9
E0641	E0673	A,P,R
E0675	E0675	R
E0676	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
E0762	E0764	A,P,R
E0765	E0765	A,P,R
E0769	E0769	9
E0770	E0770	A,P,R
E0776	E0776	A,E,P,R
E0779	E0780	A,P,R

First Code	Last Code	TOS
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	E0840	A,P,R
E0849	E0849	A,P,R
E0850	E0900	A,P,R
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	*E0986*	A,P,R
E0988	*E0988*	*R*
E0990	*E1030*	*A,P,R*
E1031	E1060	R
E1065	E1069	A,P,R

First Code	Last Code	TOS
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
E1229	E1239	A,P,R
E1240	E1295	R
E1296	E1310	A,P,R
E1340	E1340	9
E1353	E1353	R
E1354	E1354	A,P,R
E1355	E1355	R
E1356	E1372	A,P,R
E1375	E1392	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

First Code	Last Code	TOS
E1805	E1840	P,R
E1841	E1841	R
E1900	E1902	A,P,R
E2000	E2000	R
E2100	E2101	A,P,R
E2120	E2120	R
E2201	E2396	A,P,R
E2397	E2397	P
E2399	E2399	A,P,R
E2402	E2402	R
E2500	*E2633*	A,P,R
E8000	E8002	9
G0001	G0001	5
G0002	G0002	2
G0004	G0007	5
G0008	G0009	V
G0010	G0010	1
G0015	G0016	5
G0022	G0024	1
G0025	G0025	S
G0026	G0027	5
G0030	G0050	4
G0101	G0102	1
G0103	G0103	5

First Code	Last Code	TOS
G0104	G0105	2
G0106	G0106	4
G0107	G0107	5
G0108	G0113	1
G0114	G0114	3
G0115	G0116	1,T
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
G0151	G0164	1
G0165	G0165	4
G0166	G0168	1
G0169	G0169	1,W
G0170	G0171	2
G0172	G0172	U
G0173	G0174	2

First Code	Last Code	TOS
G0175	G0175	1
G0176	G0177	U
G0178	G0178	6
G0179	G0182	1
G0184	G0187	2
G0188	G0188	4
G0190	G0203	1
G0204	G0234	4
G0235	G0235	1
G0236	G0236	4
G0237	G0239	1,U,W
G0240	G0240	1
G0241	G0243	2
G0244	G0247	1
G0248	G0249	5
G0250	G0250	1
G0251	G0255	4
G0256	G0256	2
G0257	G0259	1
G0260	G0260	F
G0261	G0261	2
G0262	G0262	4
G0263	G0264	1
G0265	G0267	5

First Code	Last Code	TOS
G0268	G0268	2
G0269	G0272	1
G0273	G0274	6
G0275	G0278	2
G0279	G0283	1,U,W
G0288	G0288	4
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	G0323	M
G0324	G0327	1
G0328	G0328	5
G0329	G0329	1,U,W
G0332	G0332	1
G0336	G0336	4
G0337	G0340	1
G0341	G0343	2
G0344	G0363	1
G0364	G0364	2

First Code	Last Code	TOS
G0365	G0368	5
G0369	G0371	9
G0372	G0372	1
G0373	G0376	9
G0377	G0384	1
G0389	G0389	4
G0390	G0390	1
G0392	G0393	2
G0394	G0394	5
G0396	G0397	1
G0398	G0400	5
G0402	G0402	1
G0403	G0405	5
G0406	G0408	3
G0409	G0411	1
G0412	G0415	2
G0416	G0419	5
G0420	G0424	1
G0425	G0427	3
G0428	G0429	2
G0430	G0434	5
G0435	G0435	9
G0436	*G0447*	1
G0448	*G0448*	*2*

First Code	Last Code	TOS
G0451	G9140	1
G9141	G9142	V
G9143	G9143	*1*
G9147	*G9147*	9
G9156	*G9156*	*1*
H0001	H2037	9
J0120	J0210	1,P
J0215	J0215	1,G
J0220	*J0257*	1,P
J0270	J0275	1
J0278	J0476	1,P
J0480	J0480	1,G
J0490	J0594	1,P
J0595	J0595	1
J0597	J0880	1,P
J0881	J0882	1,L
J0885	J0885	9
J0886	J0886	1,L
J0894	J1642	1,P
J1644	J1644	1,L,P
J1645	J1670	1,P
J1675	J1675	1,G
J1680	J1820	1,P
J1825	J1830	1

First Code	Last Code	TOS
J1835	J2916	1,P
J2920	J2930	1,G
J2940	J3395	1,P
J3396	J3396	9
J3400	*J7180*	1,P
J7183	*J7183*	*1*
J7184	*J7199*	*1,P*
J7300	J7307	9
J7308	J7308	1
J7309	J7310	9
J7311	J7311	Q
J7312	J7312	1,P
J7315	J7324	1
J7325	J7330	1,P
J7335	J7335	9
J7340	J7349	1
J7350	J7350	1,S
J7500	J7599	1,G
J7604	J8499	1,P
J8501	J8501	1,G
J8510	J8521	1,P
J8530	J8530	1,G,P
J8540	J8540	1
J8560	J8560	1,P

First Code	Last Code	TOS
J8561	*J8561*	*1,G*
J8562	J8565	9
J8597	J8597	1
J8600	J8600	1,P
J8610	J8610	1,G,P
J8650	J8650	1,G
J8700	J9212	1,P
J9213	J9216	G
J9217	J9999	1,P
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

First Code	Last Code	TOS
K0174	K0174	A,P,R
K0175	K0176	P
K0177	K0177	A,P,R
K0178	K0178	P
K0179	K0181	A,P,R
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

First Code	Last Code	TOS
K0501	K0501	R
K0503	K0529	P
K0530	K0531	A,P,R
K0532	K0534	R
K0535	K0537	S
K0538	K0538	R
K0539	K0540	P
K0541	K0547	A,P,R
K0548	K0548	1,P
K0549	K0550	R
K0551	K0551	A,P,R
K0552	K0552	P
K0553	K0555	A,P,R
K0556	K0597	P
K0600	K0608	A,P,R
K0609	K0609	P
K0610	K0614	L
K0615	K0617	A,P,R
K0618	K0619	P
K0620	K0626	S
K0627	K0627	A,P,R
K0628	K0629	J
K0630	K0649	P
K0650	K0669	A,P,R

First Code	Last Code	TOS
K0670	K0670	P
K0671	K0671	R
K0672	K0672	P
K0730	K0730	A,P,R
K0731	K0732	P
K0733	K0737	A,P,R
K0738	K0738	P,R
K0739	K0740	9
K0741	*K0741*	*P,R*
K0742	*K0742*	*P*
K0743	*K0743*	*R*
K0744	*K0746*	*S*
K0800	K0899	A,P,R
L0100	L3963	P
L3964	L3966	A,P,R
L3967	L3967	P
L3968	L3970	A,P,R
L3971	L3971	P
L3972	L3972	A,P,R
L3973	L3973	P
L3974	L3974	A,P,R
L3975	L8100	P
L8110	L8120	P,S
L8130	L9900	P

First Code	Last Code	TOS
M0064	M0300	1
M0301	M0301	2
M0302	P7001	5
P9010	P9011	0
P9012	P9012	9
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

First Code	Last Code	TOS
Q0086	Q0086	9
Q0091	Q0091	1
Q0092	Q0092	4
Q0111	Q0115	5
Q0132	Q0136	9
Q0137	Q0137	1,L
Q0138	Q0139	1,P
Q0144	Q0144	1
Q0156	*Q0162*	1,P
Q0163	Q0181	1
Q0182	Q0185	S
Q0186	Q0186	1
Q0187	Q0187	1,P
Q0188	Q0188	9
Q0478	Q0506	P
Q0510	Q0514	9
Q0515	Q0515	1,P
Q1001	Q1005	F
Q2001	Q2018	1,P
Q2019	Q2019	1,G
Q2020	Q2024	1,P
Q2025	Q2027	1,9
Q2035	Q2039	V
Q2040	*Q2040*	*1, P*

First Code	Last Code	TOS
Q2041	*Q2042*	*1,9*
Q2043	*Q2043*	*1*
Q2044	*Q2044*	*1, 9*
Q3001	Q3001	1
Q3014	Q3014	9
Q3025	*Q3026*	1,P
Q3031	Q3031	5
Q4001	Q4051	S
Q4052	Q4053	1,P
Q4054	Q4055	1,L
Q4074	Q4077	1,P
Q4078	Q4078	4
Q4079	Q4080	1,P
Q4081	Q4082	1,L
Q4083	Q4086	1
Q4087	Q4099	1,P
Q4115	*Q4130*	1
Q5001	Q9940	1,L
Q9941	Q9944	1,P
Q9945	Q9968	4
R0070	R0075	4
R0076	R0076	5
S0009	S0011	1,P
S0012	S0012	1

First Code	Last Code	TOS
S0014	S0087	1,P
S0088	S0088	9
S0090	S0090	1,P
S0091	S0093	9
S0096	S0098	1,P
S0104	S0104	1
S0106	S0108	9
S0112	S0112	1
S0114	*S0119*	9
S0122	S0132	1,P
S0133	S0133	9
S0135	S0135	1,P
S0136	S0169	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
S0220	S0400	9
S0500	S0592	Q

First Code	Last Code	TOS
S0595	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	S2067	2
S2068	S2109	9
S2112	S2112	2
S2113	S2371	9
S2400	S2404	2
S2405	S2405	9
S2409	S2409	2
S2411	S3800	9
S3818	S3819	5
S3820	S4980	9
S4981	S4981	2
S4989	S8001	9

First Code	Last Code	TOS
S8002	S8003	1
S8004	S8035	9
S8037	S8037	4
S8040	S8210	9
S8260	S8260	P
S8262	S8270	9
S8300	S8300	S
S8301	S8434	9
S8450	S8452	P
S8460	S8470	9
S8490	S8490	S
S8940	S9528	9
S9529	S9529	5
S9533	S9590	9
S9800	S9800	1
S9802	T1014	9
T1015	T1015	1
T1016	T4543	9
T5001	T5999	9
V2020	V2615	Q
V2623	V2629	P
V2630	V2799	Q
V5008	V5299	K
V5336	V5336	1

First Code	Last Code	TOS
V5362	V5364	1,W
00100	00103	7
00104	00104	7,T
00120	00860	7
00862	00862	7,N
00864	01999	7
10021	11012	2
11040	11044	2,U,W
11045	*20525*	2
20526	*20527*	*1*
20550	*20975*	*2*
20979	20979	6
20982	29058	2
29065	29540	2,U,W
29550	29550	1,U,W
29580	29580	1,U,W
29581	*29582*	1
29583	36410	2
36415	36415	5
36416	36416	1
36420	36510	2
36511	36516	1
36520	38200	2
38204	38204	1

First Code	Last Code	TOS
38205	38206	2
38207	38209	1
38210	38210	2
38211	38215	5
38220	38241	2
38242	38242	2
38300	43774	2
43775	50290	2
50300	50320	N
50323	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	75954	6
75956	75959	4
75960	75968	6

First Code	Last Code	TOS
75970	75970	4
75978	75989	6
75992	76082	4
76083	76085	1
76086	76091	4
76092	76092	B,C,1
76093	76934	4
76936	76936	6
76937	76937	4
76938	76938	6
76940	76940	4
76941	76942	6
76945	76945	4
76946	76965	6
76970	77051	4
77052	77052	1
77053	77056	4
77057	77057	1
77058	77084	4
77261	77370	6
77371	77373	4
77399	*77423*	*6*
77424	*77425*	*4*
77427	77435	6

First Code	Last Code	TOS
77469	*77469*	*4*
77470	77799	6
78000	78264	4
78267	78268	5
78270	78807	4
78808	78808	1
78811	78999	4
79000	79001	6
79005	79005	4
79030	79100	6
79101	79101	4
79200	79440	6
79445	79445	4
79900	79999	6
80047	80440	5
80500	80502	3
81000	88319	5
88321	88332	3
88333	89399	5
90281	90468	1
90470	90470	V
90471	90636	1
90644	90644	9
90645	90650	1

First Code	Last Code	TOS
90654	90664	V
90665	90665	1
90666	90670	V
90675	90727	1
90732	90732	V
90733	90802	1
90804	*90865*	1,T
90867	*90869*	*1*
90870	*90899*	1,T
90901	90911	1,U,W
90918	90921	M
90922	90999	1
91000	91012	5
91013	91013	1
91020	91033	5
91034	91040	1
91052	91065	5
91100	91105	2
91110	91111	4
91117	91120	1
91122	91122	5
91123	91123	1
91132	91133	5
91299	91299	2

First Code	Last Code	TOS
92002	92014	1
92015	92015	Q
92018	92020	1
92025	92025	5
92060	92060	1
92065	*92070*	Q
92071	*92072*	*1*
92081	92130	Q
92132	92134	1
92135	92226	Q
92227	92228	1
92230	92396	Q
92499	92504	1
92506	92508	1,U,W
92510	92510	K,U,W
92511	92520	1
92525	92526	1,U,W
92531	92550	1
92551	*92557*	K
92558	*92558*	*1*
92559	92569	K
92570	92570	1
92571	92596	K
92597	92598	1,W

First Code	Last Code	TOS
92599	92616	1
92617	92617	2
92618	92633	1
92640	92640	9
92700	92971	1
92973	92977	2
92978	92979	4
92980	92998	2
93000	93278	5
93279	93292	1
93303	93352	5
93451	93463	2
93464	93464	1
93501	93545	2
93555	93556	4
93561	93662	2
93668	93668	9
93701	93744	5
93745	93750	1
93760	93888	5
93890	93893	6
93922	93981	5
93982	93982	1
93990	*93998*	5

First Code	Last Code	TOS
94002	94005	1
94010	94450	5
94452	94610	1
94620	94621	5
94640	94668	1
94680	94772	5
94774	94774	1
94775	94776	9
94777	94777	1
94779	94799	5
94780	*94781*	*1*
95004	95801	1
95803	95830	5
95831	95852	5,U,W
95857	95870	5,W
95872	95927	5
95928	95929	1
95930	95930	Q
95933	95962	5
95965	95967	4
95970	95975	5
95978	95992	1
95999	95999	5
96000	96003	1,W

First Code	Last Code	TOS
96004	96004	1
96020	96020	4
96040	96103	1
96105	96115	5,U,W
96116	96120	5
96150	96155	9
96400	96567	1
96570	96571	2
96900	96913	1
96920	96922	2
96999	96999	1
97001	97546	1,U,W
97597	97598	1
97601	97602	1,U,W
97605	97606	1
97703	97799	1,U,W
97802	98969	1
99000	99002	9
99024	99060	1
99070	99071	9
99075	99091	1
99100	99150	7
99170	99170	5
99172	99173	Q

First Code	Last Code	TOS
99174	99239	1
99241	99275	3
99281	99444	1
99450	99456	9
99460	99539	1
99551	99569	9
99600	99600	1
99601	99607	9
0001F	0500F	1
0501F	0501F	9
0502F	7025F	1
0001T	0002T	2
0003T	0003T	9
0005T	0009T	2
0010T	0010T	5
0012T	0020T	2
0021T	0021T	1
0023T	0023T	5
0024T	0024T	2
0025T	0026T	9
0027T	0027T	2
0028T	0028T	4
0029T	0029T	9
0030T	0031T	5

First Code	Last Code	TOS
0032T	0039T	2
0040T	0040T	4
0041T	0041T	5
0042T	0043T	4
0044T	0045T	9
0046T	0057T	2
0058T	0060T	5
0061T	0063T	2
0064T	0064T	5
0065T	0065T	1
0066T	0066T	2
0067T	0070T	4
0071T	0072T	2
0073T	0073T	4
0074T	0074T	1
0075T	0076T	6
0077T	0081T	2
0082T	0083T	6
0084T	0084T	1
0085T	0085T	5
0086T	0086T	1
0087T	0087T	5
0088T	0088T	6
0089T	0089T	9

First Code	Last Code	TOS
0090T	0102T	2
0103T	0110T	9
0111T	0111T	5
0115T	0117T	9
0120T	0126T	2
0130T	0133T	9
0135T	0137T	2
0140T	0140T	9
0141T	0143T	2
0145T	0152T	4
0153T	0153T	2
0154T	0154T	4
0155T	0158T	2
0159T	0159T	4
0160T	0161T	6
0162T	0162T	9
0163T	0173T	2
0174T	0175T	4
0176T	0177T	2
0178T	0180T	5
0181T	0181T	Q
0182T	0182T	6
0183T	0183T	9
0184T	0185T	1

First Code	Last Code	TOS
0186T	0186T	2
0187T	0190T	9
0191T	0193T	2
0194T	0194T	5
0195T	0196T	2
0197T	0197T	6
0198T	0199T	1
0200T	0202T	2
0203T	0207T	1
0208T	0222T	9
0223T	0225T	4
0226T	0232T	2
0233T	0233T	9
0234T	0238T	2
0239T	0244T	9
0245T	0259T	2
0260T	0261T	1
0262T	*0271T*	*2*
0272T	*0273T*	*1*
0274T	*0277T*	*2*
0278T	*0278T*	*1*
0279T	*0281T*	*5*
0282T	*0284T*	*2*
0285T	*0287T*	*9*

First Code	Last Code	TOS
0288T	*0288T*	*1*
0289T	*0290T*	*2*
0291T	*0292T*	*1*
0293T	*0294T*	*2*
0295T	*0299T*	*1*
0300T	*0300T*	*2*
0301T	*0301T*	*1*

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. 2098, Issued: 11-19-10, Effective Date: 04-01-11, Implementation Date: 04-04-11)

Code	Physician Specialty
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice

Code	Physician Specialty
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

Code	Physician Specialty
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
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
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

Code	Physician Specialty
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty

10.8.3 - Nonphysician Practitioner, Supplier, and Provider Specialty Codes

(Rev. 2248, Issued: 06-24-11, Effective: 04-01-11, Implementation: 04-04-11)

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	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

Code	Non-physician Practitioner/Supplier/Provider Specialty
80	Licensed Clinical Social Worker
87	All other suppliers, e.g., Drug Stores
88	Unknown Supplier/Provider
89	Certified Clinical Nurse Specialist
95	Open
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
B2	Pedorthic Personnel
B3	Medical Supply Company with Pedorthic Personnel
B4	Rehabilitation Agency
B5	Ocularist

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. <u>No Allowed Services</u> – (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#
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 Diagnostic Tests (This CR fully rescinds and replaces CR 7278) – This CR rescinded and replaced by CR 7516, Transmittal 2261	01/03/2012	7413
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	03/21/2011	7018

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		Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set		
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
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

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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
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

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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 - Rescinded and replaced by Transmittal 1638	01/05/2009	6272
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	02/01/2008	5837

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		Benefits Agreement (COBA) Medigap Claim-Based Crossover Process		
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
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

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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 for Therapy Services	10/02/2006	4014
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

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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
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

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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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