



Medicare Physician Services Version

Key Concepts Outline

Module 4: CMS 1500, ICD-10-CM, NPI and Other Must-Know Billing Fundamentals

- I. The Administrative Structure of the Medicare Fee-for Service Program
 - A. Integration of Medicare Part A and Part B
 1. A/B MACs process both Part A and B claims for the fee for service benefit.
 2. MACs serve as the primary point of contact for provider enrollment, Medicare coverage, billing requirements, training, and the receipt, processing and payment of claims.
 - B. MAC Jurisdiction
 1. Service Jurisdiction
 - a. "Regular" Part B MACs process claims for the following types of services:
 - (i) Physician/practitioner services and certain "incident to" services and supplies,
 - (ii) Laboratory services (other than services furnished by hospital-based laboratories),
 - (iii) Ambulance services,
 - (iv) Ambulatory surgical center (ASC) services, and
 - (v) Independent diagnostic testing facility (IDTF) services. < Medicare Claims Processing Manual, Chapter 1 § 10.1 >
 2. Geographic Jurisdiction

- a. In general, MAC jurisdiction is based on the ZIP code where the service was furnished, rather than where the beneficiary lives. < *Medicare Claims Processing Manual*, Chapter 1 § 10.1.1>
- b. Physicians/practitioners who furnish services at multiple locations spanning more than one MAC jurisdiction, may submit their claims through one office to the MAC for processing. < *Medicare Claims Processing Manual*, Chapter 1 § 10.1.1(A)>
 - (i) However, the specific location where the services were furnished must be entered in Item 32 on the claim so that the MAC can determine (based on ZIP code) the correct claims processing jurisdiction, and can apply the correct physician fee schedule amounts. < *Medicare Claims Processing Manual*, Chapter 1 § 10.1.1(A)>

II. Claims Submission

A. Mandatory Claims Submission

1. Physicians/practitioners are required to file claims with Medicare on behalf of the beneficiary. < *Medicare Claims Processing Manual*, Chapter 1 § 70.8.8.6>

B. Beneficiary Statements

1. Beneficiaries have the right to receive an itemized statement upon request. Physicians/practitioners have 30 days from receipt of a request for an itemized statement to provide the statement. < *Medicare Program Integrity Manual*, Chapter 4 § 4.20.5.1>

C. Electronic Claims Requirement

1. Mandatory Electronic Claims Submission

- a. All "initial claims for reimbursement under Medicare" must be submitted electronically. < *Medicare Claims Processing Manual*, Chapter 24 § 90>
 - (i) Exceptions where paper claims are permitted:
 - (a) Physicians, practitioners, facilities or suppliers with fewer than 10 full time equivalent (FTEs) employees. < *Medicare Claims Processing Manual*, Chapter 24 § 90.1>
 - (b) Roster billers < *Medicare Claims Processing Manual*, Chapter 24 § 90.2.1>
 - (c) Some demonstration project claims < *Medicare Claims Processing Manual*, Chapter 24 § 90.2.2>

(d) Limited number of Medicare Secondary Payer claims < *Medicare Claims Processing Manual*, Chapter 24 § 90.2.3>

(e) Claims submitted by beneficiaries < *Medicare Claims Processing Manual*, Chapter 24 § 90.2.6>

2. Application of HIPAA's "Transaction Standards to Physician/Practitioner Claims"

a. Background

(i) HIPAA required the development of "standards" for "electronic data transactions used in the administration of health care and data claims." < *Medicare Claims Processing Manual*, Chapter 26 § 10.5>

b. Transaction Standards for Physician/Practitioner Claims

(i) Effective January 1, 2012, the HIPAA standard format for physician/practitioner claims, the "ASC X12 837" is the 5010 standard. <MLN Matters Article SE0904>

(a) The 5010 standard contains several improvements, including the ability to report and accept ICD-10 diagnosis and procedure codes. < *MLN Matters* Article SE0904>

c. Paper Claim Form CMS-1500 (02/12)

(i) Despite the conversion to electronic format, the CMS-1500 remains the template of organizing the claim data fields.

(ii) In association with CMS, the National Uniform Claim Committee (NUCC) revised the CMS 1500 08/05 to CMS 1500 02/12. Among other changes, the revised form better accommodates ICD-10 CM codes and expands the diagnosis code reporting ability from 4 codes to 12 codes. < *MLN Connects Provider eNews*, June 27, 2013>

(a) Effective April 1, 2014 – Only the 02/12 version will be accepted for paper claims.

D. Unprocessable Claims

1. If a claim lacks the necessary information needed for processing, the MAC will return the claim to the submitter as "unprocessable." < *Medicare Claims Processing Manual*, Chapter 26 § 10.1>

III. Key CMS-1500 "Items" < *Medicare Claims Processing Manual*, Chapter 26 §§ 10.2 through 10.4>

A. Item 9 – Medigap Policy Information

1. Medigap Insurance

- a. Medigap is Medicare supplemental insurance, sold by private insurance companies, with the purpose of filling the “gaps” in Medicare coverage.
 - (i) However, not all insurance that is secondary to Medicare is Medigap insurance. For example, employers sometimes offer retirement insurance plans as a benefit to their retirees. Employer sponsored insurance plans are not considered to be Medigap insurance.

2. Reporting Information in Item 9

- a. Item 9 (including Items 9a through 9d) should be completed if the physician/practitioner is participating and the beneficiary has assigned his/her right to payment under a Medigap policy to the physician/practitioner. If no Medigap benefits are assigned, this item should be left blank.
 - (i) If a policy number is reported in Item 9a, the policy number must be preceded by “MEDIGAP,” “MG,” or “MGAP.”
- b. Item 9c may be left blank if the Medigap Payer ID is entered in Item 9d. Otherwise this item should contain the claims processing address of the Medigap insurer.
- c. Item 9d is where the Medigap insurer identification number is reported. Each Medigap plan will be assigned an identification number in the range of 55000 through 59999. <MLN Matters Article MM5662>
- d. If Items 9 and 9a-d are completed (and the information is accurate), the MAC is required to automatically forward the claim on to the Medigap insurer for secondary processing.
 - (i) CMS refers to this process as a “mandated Medigap transfer.”

B. Item 10 – Other Insurance

- a. The answers to the Item 10 questions are used by the MAC to determine whether another party may have liability primary to Medicare.

C. Item 11 – Another Health Plan

- 1. Item 11 is used by the MAC to identify other insurance that might have liability on the claim primary to Medicare.

- a. Completion of Item 11 is mandatory. Although not entirely clear, it appears that CMS may take the position that physicians/practitioners have an affirmative duty to make a good faith effort to identify any other insurance that may be primary to Medicare.

(i) Situations where other insurance may be primary to Medicare include:

(a) Group Health Plan Coverage:

1. Working Medicare beneficiaries covered under an employer group health plan,
2. Disabled Medicare beneficiaries covered under a private insurance plan,
3. Medicare beneficiaries with end stage renal disease who are covered under an employer group health plan,

(b) Situations where no fault and/or other liability coverage may be applicable,

(c) Work-related illnesses and injuries:

1. Workers' compensation,
2. Medicare beneficiaries with black lung disease,
3. Medicare beneficiaries with VA benefits.

(ii) Medicare Secondary Payer (MSP) claims can be submitted electronically. For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary insurer's explanation of benefits must be submitted to the MAC with the claim form.

D. Item 12 – Patient or Authorized Person's Signature

1. In theory, physicians/practitioners are supposed to have the beneficiary sign Item 12 authorizing the release of information needed to process the claim and requesting payment of the claim.
 - a. As a practical matter, however, because all Medicare claims must now be submitted electronically, physicians/practitioners must obtain the beneficiary's signature on a separate authorization form and report "Signature on File" in Item 12. <Medicare Claims Processing Manual, Chapter 1 § 50.1.1>

- (i) Medicare Claims Processing Manual, Chapter 1 § 50.1.2 provides a sample authorization form. Although that form is designed for use by hospitals and other “providers,” presumably, it could be adapted for use by physicians/practitioners.
- b. If the beneficiary is unable to provide the authorization (e.g., due to mental or physical incapacity) a representative of the beneficiary may sign on behalf of the beneficiary.
 - (i) Medicare Claims Processing Manual, Chapter 1 § 50.1.3 provides guidance on who may sign the authorization on behalf of the beneficiary.
- c. There are limited exceptions to the beneficiary signature requirement. Those exceptions are set forth in Medicare Claims Processing Manual, Chapter 1 § 50.1.6.

E. Item 13 – Assignment Authorization

- 1. According to the Claims Processing Manual, Item 13 is used to document the beneficiary’s signature authorizing the applicable Medigap insurer to pay the physician/practitioner directly.
 - a. If completed with a “signature on file,” the information on file must be specific to the Medigap insurer indicated in Item 9.
- 2. Although not discussed in the Claims Processing Manual, presumably, Item 13 could also be used to document the beneficiary’s signature authorizing assignment for an assigned claim submitted by a non-participating physician/practitioner.

F. Item 14 – Date of Illness or Injury

- 1. Item 14 is used to report the date of the “first symptom” of illness or, for an injury, the date of the “accident.” Chiropractors report the date of the initiation of a course of treatment.
 - a. Item 14 includes a space for a qualifier.
 - (i) Medicare does not use the information; therefore, the qualifier field is to be left blank<Medicare Claims Processing Manual, Chapter 26 § 10.4>

G. Item 15 – Date of Same or Similar Illness

- 1. Item 15 is not required on Medicare claims and should be left blank.

H. Item 16 - Dates Unable to Work

1. Item 16 is used for employed beneficiaries to indicate the dates that the beneficiary is unable to work.

I. Item 17 – Name of Referring Provider or Other Source

1. When a service or item is the result of an order or referral from a practitioner, the name of that practitioner must be reported in Item 17.

- a. 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 performed the initial service and orders the non-physician service must appear in item 17. <Medicare Claims Processing Manual, Chapter 26 § 10.4>
- b. A qualifier should precede the name to identify the role that the practitioner is performing: <Medicare Claims Processing Manual, Chapter 26 § 10.4>
 - (i) DN = Referring Provider
 - (ii) DK = Ordering Provider
 - (iii)DQ = Supervising Provider

2. Item 17b- Referring or Ordering Physician NPI

- a. Item 17b is required when a service was ordered or referred. It should reflect the NPI of the physician/practitioner reported in Item 17. <Medicare Claims Processing Manual, Chapter 26 § 10.4>
- b. Services Requiring an Ordering or Referring NPI
 - (i) 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 NPI. These services include:
 - (a) Parenteral and enteral nutrition
 - (b) Immunosuppressive drugs
 - (c) Hepatitis B claims
 - (d) Diagnostic laboratory services
 - (e) Diagnostic radiology services

- (f) Portable x-ray services
- (g) Telehealth consultative services
- (h) Durable medical equipment.

(ii) Exception to the NPI Ordering/Referring Requirement

- (a) Some claims do not require the reporting of an ordering/referring NPI. If the claim does not list a service that was ordered or referred, then there is no requirement to report a referring/ordering NPI. <Medicare Claims Processing Manual, Chapter 26 § 10.4>

(iii) Reporting the Ordering/Referring/Supervising Physician/Practitioner

- (a) Services Referred or Ordered or Supervised By a Different Physician/Practitioner From the Performing Physician/Practitioner <Medicare Claims Processing Manual, Chapter 26 § 10.4>

1. The name of the ordering/referring/supervising physician is reported in Item 17 and the NPI for the ordering/referring/supervising physician is reported in Item 17b. When a claim involves multiple referring, ordering, or supervising physicians, use a separate CMS-1500 claim form for each ordering, referring, or supervising physician.
2. When a service is performed incident to the service of a physician or a non-physician practitioner, the name of the physician or non-physician who performed the initial service and orders the non-physician service should be reported in Items 17 and 17b.

- (b) Services Referred or Ordered By the Performing Physician/Practitioner

1. The name and NPI of the performing physician/practitioner is reported in Items 17 and 17b. <Medicare Claims Processing Manual, Chapter 26 § 10.4>

J. Item 18 – Hospitalization Dates Related to Current Services

1. If the claim involves hospitalization-related services (presumably, this is intended to mean “inpatient” services), the dates of the hospitalization must be reported in Item 18.

K. Item 19 – Reserved for Local Use

1. Often referred to as the narrative field by MACs, Item 19 is used to report additional information specific to the services billed on the claim.
2. The information reported in Item 19 will vary based on the circumstances. Information which may be reported in Item 19 includes (but is not limited to):
 - a. The date the patient was last seen by his/her “attending physician” (and the attending’s NPI) for services furnished by physicians providing routine foot care.
 - b. The x-ray date for chiropractic services.
 - c. The name (and, for drugs, dosage) of a not otherwise classified (“NOC”) or “unlisted” service or item.
 - d. Additional modifiers, when modifier “-99” is reported in 24D.
 - e. Information identifying a beneficiary as “homebound” when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient.
 - f. The date care was transferred when practitioners share the post-operative care of a global surgery claim. <Medicare Claims Processing Manual, Chapter 26 § 10.4>
 - g. The NPI of the physician who is performing the purchased interpretation of a diagnostic test.
 - h. Information documenting a beneficiary’s refusal to assign benefits.
 - (i) If the beneficiary absolutely refuses to assign benefits to a non-participating practitioner, the MAC may not send payment on a claim to the practitioner, even if he or she is willing to accept assignment. <Medicare Claims Processing Manual, Chapter 26 § 10.4>
 - (a) This allows the patient to pull assignment of benefit rights from non-participating practitioners. In this case, non-participating practitioners may not accept assignment and payment is made to the beneficiary.
 - (b) In “mandatory assignment” situations where payment can be made only on an assignment basis or when services are furnished by a participating physician or supplier, the beneficiary (or the person authorized to request payment on the beneficiary’s behalf) is not

required to assign the claim to the physician or supplier in order for an assignment to be effective. <Medicare Claims Processing Manual, Chapter 1 § 30.3.2>

L. Item 20 – Outside Laboratory

1. Item 20 is used in connection with billing for “purchased diagnostic tests”.

M. Item 21 – Patient’s Diagnosis and Condition

1. The patient’s diagnosis(es) should be reported in Item 21. Item 21 will accommodate up to 12 diagnosis codes. Decimal points should not be reported on the claim.
2. The “ICD Indicator” identifies the ICD code set being reported. Enter the applicable ICD indicator according to the following:
 - a. Indicator 9 = ICD-9-CM code set (code set valid through 9/30/15 for Medicare)
 - b. Indicator 0 = ICD-10-CM code set (code set valid effective 10/1/15 for Medicare)
3. Sequencing of Diagnosis Codes
 - a. According to the Claims Processing Manual, the diagnosis codes should be listed in “priority order.” Presumably this means that the usual sequencing guidelines for physician/practitioner services should be followed.
 - (i) A good source for the ICD-10-CM sequencing guidelines is the “ICD-10-CM Official Guidelines for Coding and Reporting” available from the National Center for Health Statistics web site.
4. CMS requires contractors to process all diagnosis codes reported on a claim (both paper and electronic), up to the maximum permitted under the format. <Medicare Claims Processing Manual, Chapter 1 § 80.6>

N. Item 22 – Medicaid Resubmission

1. Item 22 is not required by Medicare and should be left blank on Medicare claims.

O. Item 23 – Prior Authorization Number

1. Item 23 is used for miscellaneous purposes, some of which do not have anything to do with prior authorization. Examples of circumstances where

information is required to be reported in Item 23 include (but are not limited to) circumstances involving:

- a. Investigational Device Exemption (IDE) number when an investigational device is used in FDA-approved clinical trials.
- b. The NPI of the home health agency or the hospice when care plan oversight services are reported.
- c. The Clinical Laboratory Improvement Act ("CLIA") number of the performing laboratory when laboratory services are billed.

P. Item 24 – Line Item Charges

1. Item 24B – Place of Service ("POS") < *Medicare Claims Processing Manual*, Chapter 26 §§ 10.5, 10.6; Chapter 12 § 20.4.2 >

a. Purpose of POS Codes

(i) The POS code identifies the setting where the services were furnished.

(a) The POS codes are a set of standard national codes mandated by the HIPAA Standards for Electronic Transactions.

(b) The POS code list is published in the Medicare Claims Processing Manual, Chapter 26 § 10.5.

(c) A valid POS code is required for all line items listed in Item 24.

(ii) Importance of the POS Codes

(a) Most POS codes are identified as either a "Facility" place of service or a "Non-Facility" place of service.

1. If the POS code is a "Facility" code, the fee schedule amount will be calculated based on the Facility Practice Expense RVU. If the POS code is a "Non-facility" code, the Non-Facility Practice Expense RVU will be used in the calculation for the allowable amount.

a. In general, the fee schedule amount is higher for services furnished in a non-facility setting because physicians/practitioners incur overhead expenses in a non-facility setting (such as office staff overhead) that they do not incur for services furnished in a facility setting such as a hospital.

2. CMS has instructed the Contractors to edit for “inconsistencies” between the POS code reported and the service billed.
 - a. For example, one would not expect an office/outpatient visit code to be billed with POS 21 (Hospital Inpatient).
3. New/Revised POS codes effective January 1, 2016 – Outpatient Hospital <MLN Matters Article MM9231>
 - a. New - POS 19 - Off Campus Outpatient Hospital: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
 - b. Revised - POS 22 - On Campus Outpatient Hospital: A portion of a hospital’s main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
 - c. Replaces previous ‘Outpatient Hospital’ POS to differentiate between on campus OP departments and off campus provider based departments.
2. Item 24C – EMG
 - a. Item 24c is not required by Medicare and should be left blank on Medicare claims.
3. Item 24D – Procedures, Services and Supplies
 - a. The appropriate HCPCS code for the service(s) or item(s) furnished must be reported in Item 24D.
 - (i) **Caution:** In some cases, Medicare guidelines may require the use of a specific HCPCS Level II code even though a CPT code (i.e., a HCPCS Level I) code also exists for the service/item.
4. Item 24E – Diagnosis Pointer
 - a. Item 24 is used to relate each service/item billed back to one of the 12 diagnoses listed in Item 21.

(i) The diagnosis code pointer letter listed in Item 24E should be based on the "primary" diagnosis for the service/item.

(a) This requirement is, to some extent, inconsistent with the Official ICD-10-CM Guidelines which require that diagnosis codes be assigned based on the entire encounter, rather than the individual items/services furnished during the encounter.

(ii) Only one diagnosis code pointer letter should be listed for each service/item billed. <Medicare Claims Processing Manual, Chapter 26 § 10.4>

(a) The diagnosis pointer will be a letter from A-L.

5. Item 24G – Days or Units

a. Item 24G is used to indicate the number of days or units furnished. Although it is a required field, the MACs have been instructed to default Item 24G to "1" if left blank.

(i) The method of reporting units is dependent upon the type of service or supply billed. Situations where it may be appropriate to report more than one unit include:

(a) Multiple visits

(b) Multiple units of drugs or supplies

(c) Anesthesia minutes

(d) Oxygen volume.

6. Item 24H – EPSDT Family Plan

a. This item is not used by Medicare and should be left blank.

7. Item 24I – ID QUAL.

a. Enter the ID qualifier 1C in the shaded portion.

(i) Presumably, this indicates an NPI.

8. Item 24J – Rendering Provider ID#

a. The rendering practitioner's NPI should be reported if the practitioner is a member of a group practice in the lower non-shaded portion.

- (i) For “incident to” services where a practitioner other than the attending physician (i.e., the physician to whom the services were “incident to”) supervised the furnishing of the “incident to” services, the supervising physician’s NPI should be reported in Item 24J.
- (ii) If services billed on a single claim were furnished by multiple physicians/practitioners, each physician’s/practitioner’s individual NPI should be entered in Item 24J on the appropriate line. <Medicare Claims Processing Manual, Chapter 26, § 10.4>
- (iii) If the physician/practitioner is a member of a group practice:
 - (a) The individual NPI of the physician/practitioner who furnished the service should be reported on the CMS-1500 form in the unshaded portion of Item (i.e., field) 24J. <Medicare Claims Processing Manual, Chapter 26 § 10.4>
 - (b) The group NPI should be reported in Item 33a, as will be discussed later. <Medicare Claims Processing Manual, Chapter 26 § 10.4>
- (iv) If the physician/practitioner is not a member of a group practice:
 - (a) The individual NPI of the physician/practitioner who furnished the service should be reported in Item 33a, as will be discussed further later. <Medicare Claims Processing Manual, Chapter 26 § 10.4>
 - (b) Although not clear from the Medicare Claims Processing Manual, presumably, field 24J should be left blank if the physician/practitioner is not a member of a group practice.

Q. Item 27 – Accept Assignment

- 1. Item 27 is used to indicate whether the physician/practitioner accepts assignment on the claim.

R. Item 29 – Amount Paid

- 1. Enter the total amount the patient paid only for covered services. Do not report amounts collected for non-covered services.

S. Item 30 – Balance Due

- 1. Item 30 is not required by Medicare and should be left blank for Medicare claims.

T. Item 31 – Signature of Physician or Supplier

1. "Signature on file" and computer generated signatures are both valid entries for Item 31.
 - a. When the claim contains services reported as "incident to", the name of the physician/practitioner that supervised the provision of the services should be reported.

U. Item 32 – Service Facility Location Information

1. Enter the name, address, and ZIP code of the service location for all services including those furnished in place of service home.
 - a. If services were furnished at multiple locations, a separate claim must be submitted for each location.
2. Item 32a – Report the NPI of the service facility where the service was rendered. <Medicare Claims Processing Manual, Chapter 26, § 10.4>
3. Item 32b – This block is not used by Medicare and should be left blank.

V. Item 33 – Billing Provider Info & PH

1. Item 33 must be completed with the practitioner/supplier's billing name, address, ZIP code, and telephone number.
 - a. If the physician/practitioner is a member of a group practice, the group's name, address, ZIP code, and phone number are reported in Item 33.
 - b. If the physician/practitioner is not a member of a group practice, the individual physician's/practitioner's name, address, ZIP code, and phone number are reported in Item 33.
2. Item 33a – Enter the NPI of the billing practitioner or group practice. <Medicare Claims Processing Manual, Chapter 26 § 10.4>
 - a. For physicians/practitioners that are members of a group practice, the group NPI is reported in Item 33a <Medicare Claims Processing Manual, Chapter 26 § 10.4>
 - (i) The practitioners individual NPI is reported in Item 24j, as mentioned above <Medicare Claims Processing Manual, Chapter 26 § 10.4>
 - b. For physicians/practitioners not members of a group practice, the individual NPI of the practitioner is reported in Item 33a <Medicare Claims Processing Manual, Chapter 26 § 10.4>

(a) Although not clear from the Medicare Claims Processing Manual, presumably, field 24J should be left blank if the physician/practitioner is not a member of a group practice.

3. Item 33b – This block is not used by Medicare and should be left blank.

IV. Physician/Practitioner Billing Limitations

A. Time Limits On Filing Claims

1. Effective January 1, 2010 claims must be filed within one year from the date of service for processing consideration. <One Time Notification Manual, Transmittal 697>

a. Exceptions

(i) For purposes of the timely filing requirement, the error or misrepresentation of an employee acting on behalf of a Medicare contractor could possibly qualify for an extension of claims submission beyond one year. <One Time Notification Manual, Transmittal 697>

B. Treatment of Family Members Payment Prohibition

1. No Medicare payment is available for services furnished by a physician/practitioner to:

a. An immediate relative, or

b. A member of the physician's/practitioner's household. <Medicare Benefit Policy Manual, Chapter 16 § 130(A)>

(i) Presumably, the purpose of this prohibition is to prevent payment of Medicare benefits for services that would ordinarily be provided at no charge.

2. Key definitions for this prohibition

a. "Immediate relatives" includes:

(i) Husband or wife

(ii) Natural or adoptive parent, child or sibling

(iii) Stepparent, stepchild, stepbrother and stepsister

(iv) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law

(v) Grandparent and grandchild

(vi) Spouse of grandparent and grandchild. < *Medicare Benefit Policy Manual*, Chapter 16 § 130(B)>

b. Member of the household is considered to be anyone sharing a common home as a member of a single family unit. < *Medicare Benefit Policy Manual*, Chapter 16 § 130(C)>

3. Application to group practices

a. Although not at all clear, there is language in the Benefit Policy Manual that suggests that CMS may take the position that the payment prohibition applies not only to a particular physician/practitioner but to each immediate relative and household member of each “owner” of the group practice. < *Medicare Benefit Policy Manual*, Chapter 16 §§ 130(D), 130(E)>

V. SNF Consolidated Billing Claim Limitations

A. Concept of SNF Consolidated Billing

1. Consolidated billing is a part of the Medicare payment system for skilled nursing facility (SNF) services.

a. Under consolidated billing, the SNF is responsible for providing a wide range of services to its residents. If the SNF does not have the capability to provide a particular service included in consolidated billing, it must obtain the services from an outside source and pay the service provider directly. < *Medicare Claims Processing Manual*, Chapter 6 § 10.4>

2. Consolidated Billing Implications for Physicians/Practitioners

a. Although professional services (other than therapy services) are generally excluded from consolidated billing, it is possible that a physician/practitioner may provide therapy services or some other item or service to a SNF resident that is subject to consolidated billing. If so, it would be improper for the physician/practitioner to bill the MAC for the item or service. Instead, the physician/practitioner must look to the SNF to pay for the item or service. < *Medicare Claims Processing Manual*, Chapter 6 §§ 10.4, 20.1>

3. Determining Whether a Particular Service is Subject to Consolidated Billing (and therefore must be billed to the SNF)

- a. CMS maintains a list of services subject to/excluded from consolidated billing on the CMS web site. < *Medicare Claims Processing Manual*, Chapter 6 § 20.1.1 >
 - (i) In a Covered Part A SNF stay, services separately payable include:
 - (a) physician's professional services
 - (b) certain dialysis-related services, including covered ambulance transportation to obtain the dialysis services
 - (c) certain types of ambulance services
 - (d) erythropoietin for certain dialysis patients
 - (e) certain chemotherapy drugs
 - (f) certain chemotherapy administration services
 - (g) radioisotope services
 - (h) customized prosthetic devices.
<<https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/>>
 - (ii) Verify with your MAC on which services are covered outside of SNF Consolidated Billing
- 4. Practical Guidance for Physicians/Practitioners for Complying with the SNF Consolidated Billing Requirements < *Medicare Claims Processing Manual*, Chapter 6 §§ 10.4, 20.1 >
 - a. Physicians/practitioners should consider taking the following steps to ensure that they do not inadvertently bill the MAC for services subject to consolidated billing:
 - (i) Physicians/practitioners should implement a process for identifying patients that are SNF residents.
 - (a) For patients identified as SNF residents, internal edits should be implemented to check whether services are subject to consolidated billing before the services are billed to the MAC. Particular attention should be paid to the following categories of services subject to consolidated billing:
 1. Services furnished by physical and occupational therapists (including therapy services furnished to a SNF resident in a stay

that is not covered by Part A). <Medicare Claims Processing Manual, Chapter 6 § 10.3>

2. The technical component of diagnostic tests. <Medicare Claims Processing Manual, Chapter 6 § 80>

(ii) Physicians/practitioners who regularly furnish services to residents of a particular SNF should enter into a formal arrangement (such as a contract) with the SNF regarding services furnished to the SNF's residents. At a minimum, the arrangement should address:

(a) The SNF's responsibility to notify the physician/practitioner when a SNF resident is sent to the physician/practitioner.

(b) How the physician/practitioner will be paid by the SNF for services subject to consolidated billing.

b. The absence of a formal agreement between the facility and the physician/practitioner does not relieve the SNF of its responsibility to pay the physician/practitioner for services subject to consolidated billing.

<Medicare Claims Processing Manual, Chapter 6 § 10.4>

VI. The Reassignment Prohibition

A. Reassignment Prohibition Rules

1. Subject to certain exceptions, the regulation prohibits anyone other than the physician/practitioner who personally furnished a service from being paid for the service. <42CFR § 424.80(a); Medicare Claims Processing Manual, Chapter 1 § 30.2>

a. As a practical matter, the reassignment prohibition is also a billing restriction because, in all likelihood, CMS would take the position that it is improper for anyone other than the physician/practitioner who furnished a service to bill for the service unless one of the reassignment prohibition exceptions permits the physician/practitioner to "reassign" his or her right to payment to another person or entity.

B. Key Exceptions to the Reassignment Prohibition

1. Payment to the Physician's/Practitioner's Employer

a. A physician/practitioner may reassign payment to his or her employer, if the physician/practitioner is required as a condition of his/her employment to turn over to the employer all fees for services furnished within the

scope of the physician's/practitioner's employment. <42 CFR § 424.80(a); *Medicare Claims Processing Manual*, Chapter 1 § 30.2.1.D>

(i) The physician/practitioner must be a W2 employee. <Medicare Claims Processing Manual, Chapter 1 § 30.2.6>

b. There are special reassignment provisions applicable to physicians/practitioners who work in a university-affiliated faculty practice plan setting. <*Medicare Claims Processing Manual*, Chapter 1 § 30.2.8.2>

2. Payment for Services Furnished Pursuant to a Contractual Arrangement

a. A physician/practitioner may reassign payment to an "entity" with which the physician/practitioner has a contractual arrangement. <42 CFR §§ 424.80(b)(2), 424.80(b)(3); *Medicare Claims Processing Manual*, Chapter 1 § 30.2.7>

(i) A "contractual arrangement" reassignment is subject to the following requirements:

(a) The entity receiving payment and the physician/practitioner that furnished the service must be jointly and severally responsible for any Medicare overpayment to that entity, and

(b) The physician/practitioner furnishing the service must have unrestricted access to claims submitted by the entity for services furnished by the physician/practitioner. <*Medicare Claims Processing Manual*, Chapter 1 § 30.2.7; 42 CFR §§ 424.80(b)(2), 424.80(b)(3)>

b. Interestingly, CMS does not appear to impose any other requirements relating to the form or content of the "contractual arrangement." However, it appears that a written contract is required. <*Medicare Claims Processing Manual*, Chapter 1 § 30.2.4(C)>

3. Payment to a Billing Agent

a. Medicare payment may be made to an agent who provides billing and collection services subject to the following limitations:

(i) The agent receives the payment under an agreement with the physician/practitioner,

- (ii) The agent's compensation is not related to the amounts billed or collected,
 - (iii) The agent's compensation is not dependent upon the actual collection of payment,
 - (iv) The agent acts under payment disposition instructions that may be modified or revoked at any time,
 - (v) The agent receiving payment acts only on behalf of the physician/practitioner. <42 CFR § 424.80(b)(6); *Medicare Claims Processing Manual*, Chapter 1 § 30.2.4(A)>
- b. However, the requirements set forth above do not apply if the agent "merely prepares bills" and "does not receive and negotiate the checks payable to the provider/supplier." <Medicare Claims Processing Manual, Chapter 1 § 30.2.4(B)>

4. Reciprocal Billing (Coverage) Arrangements

- a. A physician may reassign payment for "covered visit services" to another physician if the physicians have an "occasional reciprocal" coverage arrangement. <*Medicare Claims Processing Manual*, Chapter 1 § 30.2.10>
 - (i) Such an arrangement permits the beneficiary's regular physician to bill in his or her name for services furnished by the substitute physician subject to the following requirements:
 - (a) The regular physician is unavailable to provide the visit services,
 - (b) The beneficiary had arranged or sought to receive the visit services from the regular physician,
 - (c) The substitute physician does not provide the visit services to Medicare beneficiaries over a continuous period of longer than 60 days.
 - (d) The regular physician identifies the services as substitute services by appending the -Q5 modifier (service furnished by a substitute physician under a reciprocal billing arrangement) to the HCPCS code for the services furnished by the substitute physician, and
 - (e) The regular physician must keep on file a record of each service provided by the substitute physician, and make the record available

to the MAC upon request. <Medicare Claims Processing Manual, Chapter 1 § 30.2.10>

5. Locum Tenens Arrangements

a. Locum Tenens Physicians

- (i) Typically, the term “locum tenens” refers to a substitute physician who does not have his or her own practice and moves from area to area on temporary assignments. Locum tenens typically work as independent contractors and are generally paid a fixed amount per diem. <Medicare Claims Processing Manual, Chapter 1 § 30.2.11(A)>

b. Locum Tenens Billing Arrangements

- (i) A beneficiary’s regular physician may bill for covered visit services furnished by a locum tenens physician if:
 - (a) The regular physician is unavailable to provide the visit services,
 - (b) The beneficiary arranged or sought to receive the visit services from the regular physician,
 - (c) The locum tenens physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days.
 - (d) The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis,
 - (e) The regular physician identifies the services as locum tenens services by appending the -Q6 modifier (service furnished by a locum tenens physician) to the HCPCS code for the services furnished by the locum tenens physician. <Medicare Claims Processing Manual, Chapter 1 § 30.2.11(B)>
- (ii) In the case of medical groups, a physician who has left the group and for whom the group has engaged a locum tenens physician as a temporary replacement may bill for the temporary physician for up to 60 days <Medicare Claims Processing Manual, Chapter 1 § 30.2.11(C)>
 - (a) Presumably after that 60 days, they will no longer be able to bill using a locum tenens physician
 - (b) As with other locum tenens physicians, within the first 60 days, the regular physician identifies the services as locum tenens services by

appending the -Q6 modifier (service furnished by a locum tenens physician) to the HCPCS code for the services furnished by the locum tenens physician. <Medicare Claims Processing Manual, Chapter 1 § 30.2.11(C)>

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services



Revised product from the Medicare Learning Network® (MLN)

[ICD-10-CM/PCS Billing and Payment Frequently Asked Questions](#), Fact Sheet (ICN 908974)

MLN Matters® Number: MM9231 **Revised**

Related Change Request (CR) #: CR 9231

Related CR Release Date: August 6, 2015

Effective Date: January 1, 2016

Related CR Transmittal #: R3315CP

Implementation Date: January 4, 2016

New and Revised Place of Service Codes (POS) for Outpatient Hospitals

Note: This article was revised on December 9, 2015, to clarify the effective date of POS 19. POS 19 will be accepted for any claims processed on or after January 1, 2016. That is, POS code 19 is valid for any claim, regardless of the date of service, when it is processed on or after January 1, 2016. The title of the table on page 2 was also changed for clarification. All other information is unchanged.

Provider Types Affected

This MLN Matters® Article is intended for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MAC), including Durable Medical Equipment Medicare Administrative Contractors (DME MAC) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9231, from which this article is taken, updates the “Medicare Claims Processing Manual” by:

- Revising the current Place of Service (POS) code set by adding new POS code 19 for “Off Campus-Outpatient Hospital” and revising POS code 22 from “Outpatient Hospital” to “On Campus-Outpatient Hospital;” and
- Making minor corrections to POS codes 17 (Walk-in Retail Health Clinic) and 26 (Military Treatment Facility).

Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2014 American Medical Association.

You should ensure that your billing staffs are aware of these POS code changes.

Background

As a Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entity, Medicare must comply with HIPAA's standards and their implementation guides. The currently adopted professional implementation guide for the Accredited Standards Committee (ASC) X12N 837 standard requires that each electronic claim transaction include a POS code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintains.

The POS code set provides care-setting information necessary to appropriately pay Medicare and Medicaid claims. At times, Medicaid has had a greater need for code specificity than Medicare, and many of the past years' new codes that have been developed to meet Medicaid's needs.

While Medicare does not always need this greater specificity in order to appropriately pay claims; it nevertheless adjudicates claims with the new codes to ease coordination of benefits, and to give Medicaid and other payers the setting information that they require. Therefore, as a payer, Medicare must be able to recognize any valid code from the POS code set that appears on the HIPAA standard claim transaction.



Therefore, in response to the discussion in the CY 2015 Physician Fee Schedule (PFS) final rule with comment period published on November 13, 2014 (79 FR 67572); in order to differentiate between on-campus and off-campus provider-based hospital departments, CMS is creating a new POS code (POS 19) and revising the current POS code description for outpatient hospital (POS 22).

CR 9231, from which this article is taken, provides this POS code update, effective January 1, 2016. Specifically, CR 9231 updates the current POS code set by adding new POS code 19 for "Off Campus-Outpatient Hospital" and revising POS code 22 from "Outpatient Hospital" to "On Campus-Outpatient Hospital" as described in the following table.

New and Revised POS Codes for Claims Processed on or after January 1, 2016 (Regardless of Service Date)

Code	Descriptor
POS 19 Off Campus- Outpatient Hospital	Descriptor: A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
POS 22 On Campus- Outpatient Hospital	Descriptor: A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.



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CR9231 also:

- Implements the systems and local contractor level changes needed for Medicare to adjudicate claims with the new and revised codes (your B MAC or DME MAC will develop policies as needed to edit and adjudicate claims that contain these new/revised codes according to Medicare national policy); and
- Makes minor corrections to POS codes 17 (Walk-in Retail Health Clinic) and 26 (Military Treatment Facility) by adding those two codes back into the POS list in the “Medicare Claims Processing Manual.” Those two codes were removed inadvertently from a prior version of that manual.

Additional Information Related to POS Codes 19 and 22

- Payments for services provided to outpatients who are later admitted as inpatients within 3 days (or, in the case of non-IPPS hospitals, 1 day) are bundled when the patient is seen in a wholly owned or wholly operated physician practice. The 3-day payment window applies to diagnostic and nondiagnostic services that are clinically related to the reason for the patient’s inpatient admission, regardless of whether the inpatient and outpatient diagnoses are the same. The 3-day payment rule will also apply to services billed with POS code 19.
- Claims for covered services rendered in an Off Campus-Outpatient Hospital setting (or in an On Campus-Outpatient Hospital setting, if payable by Medicare) will be paid at the facility rate. The payment policies that currently apply to POS 22 will continue to apply to this POS, and will now also apply to POS 19 unless otherwise stated.
- Reporting outpatient hospital POS code 19 or 22 is a minimum requirement to trigger the facility payment amount under the PFS when services are provided to a registered outpatient. Therefore, you should use POS code 19 or POS code 22 when you furnish services to a hospital outpatient regardless of where the face-to-face encounter occurs.
- Your MACs will allow POS 19 to be billed for G0447 (Face-to-face behavioral counseling for obesity, 15 minutes) and G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes) in the same way as those services are billed with POS code 22.

Additional Information

The official instruction, CR9231, issued to your MAC regarding this change is available at <http://www.cms.hhs.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3315CP.pdf> on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html> under - How Does It Work.

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Document History

Date of Change	Description
December 9, 2015	Revised to clarify the effective date of POS 19. POS 19 will be accepted for any claims processed on or after January 1, 2016. That is, POS code 19 is valid for any claim regardless of the date of service when it is processed on or after January 1, 2016. The title of the table on page 2 was also changed for clarification

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Medicare Benefit Policy Manual

Chapter 16 - General Exclusions From Coverage

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130 - Charges Imposed by Immediate Relatives of the Patient or Members of the Patient's Household

(Rev. 1, 10-01-03)

A3-3161, HO-260.12, B3-2332

A. General

These are expenses that constitute charges by immediate relatives of the beneficiary or by members of their household. The intent of this exclusion is to bar Medicare payment for items and services that would ordinarily be furnished gratuitously because of the relationship of the beneficiary to the person imposing the charge. This exclusion applies to items and services rendered by providers to immediate relatives of the owner(s) of the provider. It also applies to services rendered by physicians to their immediate relatives and items furnished by suppliers to immediate relatives of the owner(s) of the supplier.

B. Immediate Relative

The following degrees of relationship are included within the definition of immediate relative.

- Husband and wife;
- Natural or adoptive parent, child, and sibling;
- Stepparent, stepchild, stepbrother, and stepsister;
- Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law;
- Grandparent and grandchild; and
- Spouse of grandparent and grandchild.

NOTE 1: A brother-in-law or sister-in-law relationship does not exist between the physician, supplier or owner of a provider (or supplier) and the spouse of his wife's or her husband's brother or sister.

NOTE 2: A father-in-law or mother-in-law relationship does not exist between a physician or the owner of a provider and his or her spouse's stepfather or stepmother.

A step-relationship and an in-law relationship continues to exist even if the marriage upon which the relationship is based is terminated through divorce or through the death of one of the parties. For example, if a provider treats the stepfather of the owner after the death of the owner's natural mother or after the owner's stepfather and natural mother are divorced, or if the provider treats the owner's father-in-law or mother-in-law after the death of their spouse, the services are considered to have been furnished to an immediate relative, and therefore, are excluded from coverage.

C. Members of Patient's Household

These are persons sharing a common abode with the patient as a part of a single family unit, including those related by blood, marriage or adoption, domestic employees and others who live together as part of a single family unit. A mere roomer or boarder is not included.

D. Charges for Provider Services

Payment is not made under Part A or Part B for items and services furnished by providers to immediate relatives of the owner(s) of the providers. This exclusion applies whether the provider is a sole proprietor who has an excluded relationship to the patient, or a partnership in which even one of the partners is related to the patient.

E. Charges for Physician and Physician-Related Services

This exclusion applies to physician services, including services of a physician who belongs to a professional corporation, and services furnished incident to those services (for example, by the physician's nurse or technician) if the physician who furnished the services or who ordered or supervised services incident to their services has an excluded relationship to the beneficiary.

Professional corporation means a corporation that is completely owned by one or more physicians, and is operated for the purpose of conducting the practice of medicine, osteopathy, dentistry, podiatry, optometry, or chiropractic, or is owned by other health care professionals as authorized by State law. Any physician or group of physicians which is incorporated constitutes a professional corporation. (Generally, physicians who are incorporated identify themselves by adding letters such as P.C. or P.A. after their title.)

F. Charges for Items Furnished by Nonphysician Suppliers

This exclusion applies to charges imposed by a nonphysician supplier that is not incorporated, whether the supplier is owned by a sole proprietor who has an excluded relationship to the patient, or by a partnership in which even one of the partners is related. It does not apply to charges imposed by a corporation (other than a professional corporation), regardless of the patient's relationship to any of the stockholders, officers, or directors of the corporation or to the person who furnished the service.

140 - Dental Services Exclusion

(Rev. 1, 10-01-03)

A3-3162, HO-260.13, B3-2336

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are not covered. Structures directly supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process. However, payment may be made for certain other services of a dentist. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," §150.)

The hospitalization or nonhospitalization of a patient has no direct bearing on the coverage or exclusion of a given dental procedure.

When an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. For example, the extraction of an impacted tooth is not covered. Similarly, an alveoplasty (the surgical improvement of the shape and condition of the alveolar process) and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service, e.g., the preparation of the mouth for dentures. In like manner, the removal of the torus palatinus (a bony protuberance of the hard palate) could be a covered service. However, with rare exception, this surgery is performed in connection with an excluded service, i.e., the preparation of the mouth for dentures. Under such circumstances, reimbursement is not made for this purpose.

The extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is also covered. This is an exception to the requirement that to be covered, a noncovered procedure or service performed by a dentist must be an incident to and an integral part of a covered procedure or service performed by the dentist. Ordinarily, the dentist extracts the patient's teeth, but another physician, e.g., a radiologist, administers the radiation treatments.

Whether such services as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered.

See also the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," §70, and Chapter 15, "Covered Medical and Other Health Services," §150 for additional information on dental services.

150 - Services Reimbursable Under Automobile, No Fault, Any Liability Insurance or Workers' Compensation

(Rev. 1, 10-01-03)