Medicare
Carriers Manual
Part 4 - Professional Relations

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

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CHANGE REQUEST 2631

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2010.2 (Cont.) – 2010.2 (Cont.)	2-17 – 2-20 (4 pp.)	2-17 – 2-20 (4 pp.)

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

Effective January 1, 2004 standard systems and carriers will implement only the analysis and design phases for this CR. Carriers and standard systems will be notified in a separate follow up CR to implement the coding, testing, and implementation phases for the April 2004 release.

Section 2010.2, Items 14-33 – Provider of Services or Supplier Information, is revised for claims received on or after April1, 2004:

- to add language in Item 20 to allow for multiple purchased tests to be billed on the ASC X12 837 electronic format when certain criteria are met;
- to require that in Item 32 the address and zip code of where the service was rendered be entered on the claim for services furnished in all places of service other than the place of service home – 12;
- to require in Item 32 that only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms must be submitted.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

Item 18. Enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) 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 8-digit (MM | DD | CCYY) date patient was last seen and the NPI of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file (See §2206.1, Part 3 of MCM).

Enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) x-ray date for chiropractor services. By entering an x-ray date, and the initiation date for course of chiropractic treatment in item 14, you are certifying that all the relevant information requirements (including level of subluxation) of the §2251, Part 3 of MCM and §4118, Part 3 of MCM are on file along with the appropriate x-ray and all are available for carrier review.

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

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

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

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See §2051.1, Part 3 of MCM and §2070.1, Part 3 of MCM respectively, for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.) Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

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

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

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

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

Item 20. Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates that "no purchased tests are included on the claim." When "yes" is annotated, item 32 must be completed. When billing for purchased diagnostic tests on the Form CMS-1500, each test must be submitted on a separate claim form. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different facility service locations. See §3060.4, Part 3.

Item 21. Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for non-physician specialties must be submitted on an attachment.

Item 22. Leave blank. Not required by Medicare.

Item 23. Enter the professional review organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

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

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number of the home health agency (HHA) or hospice when CPT code 99375 or 99376 or HCPCS code G0064, G0065, or G0066 is billed.

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

Item 24a. Enter either a 6-digit (MM | DD | YY) 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.

Item 24b. Enter the appropriate place of service code(s) from the list provided in §2010.3. Identify the location, using a place of service code, for each item used or service performed.

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 Health Care Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.

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

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.

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

Item 24f. Enter the charge for each listed service.

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

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

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

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

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

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

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

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

Item 24i. Leave blank. Not required by Medicare.

Items 24j. Leave blank. Not required by Medicare.

Item 24k. Enter the PIN of the performing provider of service/supplier if they are a member of a group practice.

When several different providers of service or suppliers within a group are billing on the same Form CMS -1500, show the individual PIN in the corresponding line item.

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

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

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

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

o Clinical diagnostic laboratory services;

o Physician services to individuals dually entitled to Medicare and Medicaid;

o Participating physician/supplier services,

- o Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- o Ambulatory surgical center services for covered ASC procedures; and
- o Home dialysis supplies and equipment paid under Method II.

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 alphanumeric date (e.g., January 1, 1998) the form was signed.

Item 32. Effective for claims received on or after April1, 2004: the name, address, and zip code of the service location for all services other than those furnished in place of service home –12 must be entered; and on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms must be submitted.

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

For foreign claims, per §2312.2C, 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 §2312ff 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.

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

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

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

Item is completed for all laboratory work performed outside a physician's office. If an independent laboratory is billing, the place where the test was performed, and the UPIN must be indicated.

Item 33. Enter the provider of service/supplier's billing name, address, zip code, and telephone number.

Enter the PIN for the performing provider of service/supplier who is not a member of a group practice.

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