Medicare
Carriers Manual
Part 3 - Claims Process

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

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CHANGE REQUEST 2631

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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, as well as provider education, for the April 2004 release.

Section 3005.4, Data Element Requirements, is revised as follows for claims received on or after April 1, 2004:

● Section 3005.4.B – Number 6 is revised to provide instructions for Form CMS-1500 paper claims when more than one place of service code is included on a claim.

● Section 3005.4.C.1.c is revised to add additional criteria that will cause the claim to be treated as unprocessable:

- on a Form CMS-1500 paper claim, no more than one purchased test may be billed on one claim;
- on a Form CMS-1500 paper claim, if both the interpretation and test are billed on the same claim and the dates of service and places of service do not match;
- on an ASC X12 837 electronic claim, if more than one purchased test is billed, line level information must be provided for each total purchased service amount;
- on a Form CMS-1500 paper claim and an ASC X12 837 electronic claim, a global code is billed when the test was purchased.

● Sections 3005.4.C.1.e, 3005.4.C.1.l, 3005.4.C.2.d.2, 3005.4.C.2.h, and 3005.4.C.2.i.2 have been revised to require that services be treated as unprocessable should the name, address, and zip code of the service location not be entered for all services other than those furnished in place of service home –12.

● Section 3005.4.C.2.o is revised to clarify that "home" means place of service home – 12.

Section 3060.4, Payment to Physician for Purchased Diagnostic Tests, is revised to add some additional requirements for the completion of claims as outlined above for §3005.4.C.1.

Sections 3101, Area Carrier – Physician's Services, is deleted and replaced with 3100.1 – 3100.6.

Section 3100.1, Payment Jurisdiction for Services Paid Under the Physician Fee Schedule and Anesthesia Services, is a new section that mandates that jurisdiction will be determined by zip code and will apply to all services except those rendered at place of service home - 12.

Section 3100.2, Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April1, 2004, is a new section that mandates that the service facility location must be entered on every claim in a manner that will allow the carrier to be able to determine jurisdiction for every service on that claim. Carriers will no longer be able to use the addresses on their provider files for the service location when the place of service is office. Exception: they may continue to use the address on the beneficiary files when POS is home - 12 or any other mechanism they currently have in place to determine pricing locality when POS is home - 12.

Section 3100.3, Payment Jurisdiction for Purchased Services, is a new section that clarifies payment jurisdiction for purchased diagnostic tests and interpretations. It also clarifies that global billings will not be acceptable for purchased services.

Section 3100.4, Payment Jurisdiction for Reassigned Services, is a new section that clarifies payment jurisdiction for reassigned services.

Section 3100.5, Jurisdiction for Shipboard Services, is the former §3101C.

Section 3100.6, Exceptions to Jurisdictional Payment, is the former §3101D.

Section 3999, Exhibit 10, is revised to change the information for certain data elements for electronic claims to be consistent with the requirements of the Accredited Standards Committee X12N 837 Version 4010 Health Care Claim: Professional implementation guide.

Section 4020.2, Items 14-33 – Physician or Supplier Information, is revised for claims received on or after April 1, 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.

NOTE: References to HCFA have been changed to CMS.

Provider Education – **Carriers are not to do any provider education until they receive the follow up CR from CMS which implements the coding, testing, and implementation phases of this CR for the April 2004 release. At that time**, carriers must share the following information with providers through a posting on their website within two weeks of receiving the instruction and publish it in their next regularly scheduled bulletin. If carriers have a list-serve that targets the affected provider community, they should use it to notify subscribers that information related to the following subjects is available on their Web site: jurisdictional payment of services paid under the Medicare Physician Fee Schedule and anesthesia services; unprocessable claims; and revisions to the information required on the health insurance claim form for Medicare.

Topics to be covered:

● A general notification/reminder that jurisdictional payment of services paid under the Medicare Physician Fee Schedule and anesthesia services will be made based on the zip code of where the service is provided.

● Clarification on the billing of purchased services including the necessity of following current enrollment procedures.

Effective for claims received on or after April 1, 2004:

● How to code paper and electronic claims, when more than one place of service, other than home, is submitted for services payable under the Medicare Physician Fee Schedule and anesthesia services.

● When billing for purchased tests on the Form CMS-1500 paper claim form, each test must be submitted on a separate claim form. In this way, the appropriate service facility location zip code and the purchase price of each test will be submitted and the carrier will be able to pay the correct reimbursement rates.

● Multiple purchased tests may be submitted on electronic claims as long as appropriate service facility location information is submitted when services are rendered at different locations and the appropriate total purchased service amounts are submitted for each purchased test.

● Item 32 on the Form CMS-1500 paper claim is limited to one service facility location name and address. In most cases when a test is purchased, it has been rendered at a different service facility location from where the interpretation is performed. Therefore, a physician may only bill for a purchased test and an interpretation on the same claim when the services are rendered on the same date of service and at the same service facility location, and are submitted with the same place of service codes.

● Electronic claims submitted for purchased services may be submitted with the interpretation and the test on the same claim. In order for the carrier to pay the correct locality based fee, appropriate service facility service location information must be submitted at the line level when services are rendered at different locations. If line item data is not submitted, it will be assumed by the carrier that the services were rendered at the same service facility location.

● Providers may not submit a global billing code on paper or electronic claims when one component of the service has been purchased. In order for carriers to determine payment jurisdiction and price services correctly, the technical and professional components of the service must be submitted on separate lines of the claim.

● In order for carriers to be able to correctly determine where services were provided and pay correct locality rates, no more than one name, address, and zip code may be entered in Item 32 of the Form CMS-1500.

These instructions should be implemented within your current operating budget.

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.

CHAPTER III
CLAIMS, FILING, JURISDICTION
AND DEVELOPMENT PROCEDURES

Section

Medicare Standard Systems

Jurisdiction of Claims

Parenteral and Enteral Nutrition

Claim Number

CHAPTER III
CLAIMS, FILING, JURISDICTION
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Section

Claims Development Procedures and Situations

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CLAIMS, FILING, JURISDICTION
AND DEVELOPMENT PROCEDURES

6. If a claim lacks a valid place of service (POS) code in item 24B or contains an invalid POS in item 24B. (Use 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 physician fee schedule and anesthesia services.

7. If a claim lacks a valid procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D or contains an invalid or obsolete procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D. (Use remark code M20 if the HCPCS is missing, or M51 for an invalid/obsolete HCPCS.)

8. If a claim lacks a charge for each listed service. (Use remark code M79.)

9. If a claim does not indicate at least one day or unit in item 24G (Note: Program your system to automatically default to "1" unit when the information in this item is missing to avoid returning as unprocessable).

10. If a claim lacks a signature from a provider of service or supplier, or their representative. (See §3005.2C "Exceptions," bullet number one; Use remark code MA70 for a missing provider representative signature, or code MA81 for a missing physician/supplier/practitioner signature.)

11. If a claim does not contain in item 33:

a. A billing name, address, zip code, and telephone number of a provider of service or supplier. (Use remark code MA82.)

AND EITHER

b. A valid PIN (or NPI when effective) number or, for DMERC claims, a valid National Supplier Clearinghouse number for the performing provider of service or supplier who is not a member of a group practice. (Use remark code MA82 or M57 if another provider is involved.)

OR

c. A valid group PIN (or NPI when effective) number or, for DMERC claims, a valid National Supplier Clearinghouse number for performing providers of service or suppliers who are members of a group practice. (Use remark code MA112.)

C. Conditional Data Element Requirements.--

1. Universal Requirements.--The following instruction describes some "conditional" data element requirements which are applicable to all assigned Part B claims submitted on the Form CMS-1500 (hardcopy) or the NSF (electronic). This instruction is minimal and does not include all "conditional" data element requirements which are universal for processing a Part B claim.

Items from the Form CMS-1500 (hardcopy) have been provided. A crosswalk between Form CMS-1500 items and records and fields on the NSF and ASC X12N 837 Professional Version 4010X098 is discussed in §3005.3.

NOTE: We have specified below which remark code(s) should be used when a claim fails a particular "return as unprocessable" edit and a remittance advice is used to return the claim. In addition to the specified remark code(s), include Remark Code MA130 on returned claim(s). Reason code(s) must also be reported on every remittance advice used to return a claim or part of a claim as unprocessable.

Return a claim as unprocessable to the supplier/provider of service:

a. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified in Claim Specific Requirements) and his/her name and/or UPIN (or NPI when effective) is not present in item 17 or 17A. (Use remark code MA82.)

b. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or UPIN (or NPI when effective) of the supervising physician is not entered in items 17 or 17A. (Use remark code MA102.)

c. For diagnostic tests subject to purchase price limitations:

(1) If a "YES" or "NO" is not indicated in item 20. (Use remark code M12.)

(2) If the "YES" box is checked in item 20 and the purchase price is not entered under the word "$CHARGES." (Use remark code MA111.)

(3) If the "YES" box is checked in item 20 and the purchase price is entered under "$CHARGES", but the supplier's name, address, zip code and PIN are not entered in item 32 when billing for purchased diagnostic tests. (Use remark code MA111.)

Entries 4 – 8 are effective for claims received on or after April 1, 2004:

(4) On the Form CMS-1500, if the "YES" box is checked in Item 20, and more than one test is billed on the claim.

(5) On the Form CMS-1500, if both the interpretation and test are billed on the same claim and the dates of service and places of service do not match;

(6) On the Form CMS-1500, if the "YES" box is checked in Item 20, both the interpretation and test are submitted and the date of service and place of service codes do not match.

(7) On the ASC X12 837 electronic format, if there is an indication on the claim that a test has been purchased, more than one test is billed on the claim, and line level information for each total purchased service amount is not submitted for each test.

(8) On the Form CMS-1500 if the "YES" box is checked in Item 20 and on the ASC X12 837 electronic format if there is an indication on the claim that a test has been purchased, and the service is billed using a global code rather than having each component billed as a separate line item.

d. If a provider of service or supplier is required to submit a diagnosis in item 21 and either a ICD-9CM code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. (Use remark code M81.)

e. If modifiers "QB" and "QU" are entered in item 24D indicating that the service was rendered in a Health Professional Shortage Area, but where the place of service is other than the patient's home or the physician's office, the name, address, and zip code of the facility where the services were furnished are not entered in item 32. (Use remark code MA115.) Effective for claims

received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home -12 must be entered.

f. If a performing physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner is a member of a group practice and does not enter his or her PIN (or NPI when effective) in item 24K and the group practice's PIN (or NPI when effective) in item 33. (Use remark code MA112.)

g. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. (Use remark code MA64, MA85, MA86, MA87, MA88, MA89, or MA92 as appropriate for the missing piece(s) of data.)

h. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act number, but a Payer or Plan identification number (use PlanID when effective) is not entered in Field 11C, or the primary payer's program or plan name when a Payer or Plan ID (use PlanID when effective) does not exist. (Use remark code MA85.)

i. If a HCPCS modifier must be associated with a HCPCS procedure code or if the HCPCS modifier is invalid or obsolete. (Use remark code M20 if there is a modifier but no HCPCS, or M78 if the modifier is missing or incorrect.)

j. If a date of service extends more than one day and a valid "to" date is not present in item 24A. (Use remark code M59.)

k. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment. (Use remark code M51.)

l. If the name, address, and zip code of the facility where the service was furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office is not entered in item 32 (Use remark code MA114.) Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home - 12 must be entered.

m. Effective for claims received on or after April 1, 2004, if more than one name, address, and zip code is entered on the CMS-1500 in item 32.

2. Claim Specific Requirements.--The following instruction describes some "conditional" requirements which are claim specific, and necessary for processing a Part B claim submitted on the Form CMS-1500 (hardcopy) or the NSF or ASC X12N 837 (electronic) format. This instruction is minimal and does not include all "conditional" data element requirements. Not all "conditional" data elements apply to Medicare. The ASC X12N 837 implementation guide states when each conditional data element is required; if the condition applies, it must be used.

Items from the Form CMS-1500 have been provided. These items are referred to as records and fields, segments or data elements on electronic claims. Refer to §3005.3 for a crosswalk between Form CMS-1500 items (hardcopy) and records and fields on the NSF (electronic) and for the ASC X12N 837 Professional Version 4010X098 implementation guide for use when HIPAA is implemented.

NOTE: Some claim types covered by Part B are not included in these instructions.

Return the following claim as unprocessable to the provider of service/supplier:

a. For chiropractor claims:

1. If the x-ray date is not entered in item 19 for claims with dates of service prior to 01/01/2000. Entry of an x-ray date is not required for claims with dates of service on or after 01/01/2000.

2. If the initial date "actual" treatment occurred is not entered in item 14. (Use remark code MA122.)

b. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and the group's name, address, zip code, and PIN (or NPI when effective) number is not entered in item 33 or their personal PIN (or NPI number when effective) is not entered in item 24K. (Use remark code MA112.)

c. For durable medical, orthotic, and prosthetic claims, if the name, address, and zip code of the location where the order was accepted is not entered in item 32. (Use remark code MA 114.)

d. For physicians who maintain dialysis patients and receive a monthly capitation payment:

1. If the physician is a member of a professional corporation, similar group, or clinic, and the attending physician's PIN (or NPI when effective) is not entered in item 24K. (Use remark code MA112.)

2. If the name, address, and zip code of the facility other than the patient's home or physician's office involved with the patient's maintenance of care and training is not entered in item 32. (Use remark code MA114.) Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home - 12 must be entered.

e. For routine foot care claims, if the date the patient was last seen and the attending physician's PIN (or NPI when effective) is not present in item 19. (Use remark code MA104.)

f. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Use remark code M33 or MA102.)

g. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his or her name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Use remark code M33 or MA102.)

h. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other the patient's home or physician's office (including services to a patient in an institution), if the name, address, and zip code of the location where services were performed is not entered in item 32. (Use remark code MA114.) Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home - 12, must be entered.

i. For independent laboratory claims:

1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician

that any laboratory service(s) performed were conducted at home or in an institution by entering the appropriate annotation in item 19 (i.e., "Homebound"). (Use remark code MA116.)

2. If the name, address, and zip code where the test was performed is not entered in item 32, if the services were performed in a location other than the patient's home or physician's office. (Use remark code MA114.) Effective for claims received on or after April 1, 2004, the name, address, and zip code of the service location for all services other than those furnished in place of service home - 12 must be entered.

j. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their six-digit, FDA-approved certification number in item 32 when billing the technical or global component. (Use remark code MA128.)

k. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Use remark code MA102.)

l. For portable x-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name and/or UPIN (or NPI when effective) are not entered in items 17 or 17A. (Use remark code MA102.)

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name and/or UPIN (or NPI when effective) if appropriate are not entered in items 17 or 17A. (Use remark code MA 102.)

n. For outpatient services provided by a qualified, independent physical or occupational therapist:

(1) If the UPIN (or NPI when effective) of the attending physician is not present in Item 19. (Use remark code MA104.)

(2) If the 6-digit (MM/DD/YY) of 8-digit (MM/DD/CCYY) date patient was last seen by the attending physician is not present in item 19. (Use remark code MA104.)

o. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and zip code, and PIN (or NPI when effective) where the laboratory services were performed in item 32, if the services were performed at a location other than the place of service home –12. (Use remark code MA114.)

p. For all physician and non-physician specialty (Pas, NPs, CNSs, CRNAs, CNM, CP, CSW) claims, if an ICD-9CM code in item 21 is missing, invalid or truncated. (Use remark code M81.)

q. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998. (Use remark code MA51.)

r. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23. (Use remark code MA50.)

s. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23. (Use remark code MA 49.)

3. Physicians of the faculty practice plan are employees of the University and/or medical school. The plan should furnish a copy of the employment agreement(s) between the faculty physician and the University.

4. Physicians are full or part-time faculty members of the University's School of Medicine, licensed to practice medicine in the State.

5. The faculty practice plan may only be affiliated with one University, and this relationship is described in the written agreement between the University and the Medical Faculty Practice Plan.

6. Members of the faculty practice plan are represented on the Governing Board of the practice plan. The Board has the authority to make or delegate management and operational decisions on behalf of the physicians participating in the practice plan.

7. Faculty practice plan physicians have unrestricted access to the billing records, medical documentation, and claims forms for services submitted on their behalf by the practice plan. The faculty practice plan provides documentation establishing the existence of this policy.

8. The physicians abide by the rules and regulations of the Medical Faculty Practice Plan.

9. The faculty practice plan is accountable to Medicare for any claims that are submitted on behalf of the plan's physicians for services provided to Medicare beneficiaries. Thus, the plan is responsible for refunding any overpayments to Medicare that are collected on behalf of the plan's physicians.

Both the Medical Faculty Practice Plan and the plan's physicians must enroll in the Medicare program by completing the Form HCFA-855 and Form HCFA-855R (Medicare health care provider/supplier enrollment application forms). Instructions for processing Form HCFA-855 are referenced in Part IV, §1030 of the Medicare Carriers Manual.

For those entities that are part of the organizational structure of the University, see §3060.8B of the Medicare Carriers Manual, on payment to special accounts. These entities may include departments, specialties, practice plans, or similar subdivisions of a university or medical school.

E. Managed Care Organizations, including HCPPs, cost-contracting HMOs, CMPs, and Medicare + Choice Organizations.--Carriers may make reassigned Part B payments under limited circumstances to HCPPs, cost-contracting HMOs, CMPs, and to Medicare + Choice Organizations.

A Medicare + Choice Organization is an entity that meets the following criteria: (1) Is a public or private entity licensed by a state as a risk-bearing entity (with the exception of a provider-sponsored organization receiving a Federal waiver from state licensure requirements) that is certified by CMS as meeting the Medicare + Choice contract requirements; (2) Is responsible for the organization, financing, administration, and contracting for the delivery of covered Part A and Part B services on a prepayment arrangement basis (HCPP agreements are only for Part B services); and, (3) Arranges for the provision of Medicare + Choice plan(s) (health benefits coverage offered under a policy or contract) services to enrolled Medicare beneficiaries residing in the service area of the Medicare + Choice plan(s).

The following are circumstances under which payments may be made by a carrier to an HCPP, a cost-contracting HMO, a CMP, or a Medicare + Choice Organization:

1. The services are furnished to a beneficiary who is not a Medicare enrollee of the HCPP, HMO, or CMP, or Medicare + Choice Organization;

2. The services are furnished to a beneficiary who is a Medicare enrollee of the HCPP, HMO, CMP, or Medicare + Choice Organization, but who has not been added to CMS rolls as such;

3. The services are furnished to a beneficiary who is a Medicare enrollee of an HCPP, cost-contracting HMO, or CMP, but the services must be billed to the carrier because they are subject to certain administrative billing restrictions, e.g., independent physical therapy, blood, and end stage renal disease services;

4. The services, in the nature of attending physician services or services unrelated to a terminal illness, are furnished to a Medicare enrollee of a Medicare + Choice Organization who has elected the hospice benefit; or,

5. The services are furnished by a Medicare + Choice Organization to a Medicare enrollee, but are excluded from it's Medicare + Choice contract under §1852(a)(5) of the Social Security Act.

When an HCPP, HMO, CMP, or Medicare + Choice Organization pays the physician, medical group, or other supplier on a fee-for-service basis, and conditions 2, 3, or 4 above are met, it may claim and receive payment from the carrier for the services under the indirect payment procedure (see §7065) if it is approved as a qualified organization under that section and the other conditions for payment under §7065 are met.

3060.4 Payment to Physician for Purchased Diagnostic Tests.--A physician or a medical group may submit the claim and (if assignment is accepted) receive the Part B payment, for the technical component of diagnostic tests which the physician or group purchases from an independent physician, medical group, or other supplier. (This claim and payment procedure does not extend to clinical diagnostic laboratory tests.) The purchasing physician or group may be the same physician or group as ordered the tests or may be a different physician or group. An example of the latter situation is when the attending physician orders radiology tests from a radiologist and the radiologist purchases the tests from an imaging center. The purchasing physician or group may not markup the charge for a test from the purchase price and must accept the lowest of the fee schedule amount if the supplier had billed directly; the physician's actual charge; or the supplier's net charge to the purchasing physician or group, as full payment for the test even if assignment is not accepted. (See §15048.)

In order to purchase a diagnostic test, the purchaser must perform the interpretation. The physician or other supplier that furnished the technical component must be enrolled in the Medicare program. No formal reassignment is necessary.

Effective for claims received on or after April 1, 2004:

- In order to have appropriate service facility location zip code and the purchase price of each test on the claim, when billing for purchased tests on the Form CMS-1500 paper claim form, per §4020.2, Part 3 and §2010.3, Part 4, Item 20, each test must be submitted on a separate claim form. Treat paper claims submitted with more than one purchased test as unprocessable per §3005.

- More than one purchased test may be billed on the ASC X12 837 electronic format. When more than one test is billed, the total purchased service amount must be submitted for each service. Treat claims received with multiple purchased tests without line level total purchased service amount information as unprocessable per §3005.

- Treat paper claims submitted for purchased services with both the interpretation and the purchased test on one claim as unprocessable per §3005 unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and

the date of service and place of service codes match, assume that the one address in Item 32 applies to both services.

● ASC X12 837 electronic claims submitted for purchased services with both the interpretation and purchased test on the same claim must be accepted. Assume that the claim level service facility location information applies to both services if line level information is not provided.

● In order to price claims correctly and apply purchase price limitations, global billing is not acceptable for claims received on the Form CMS-1500 or on the ASC X12 837 electronic format. Each component must be billed as a separate line item (or on a separate claim per the limitations described above). Treat the claim as unprocessable per §3005 when a global billing is received and there is information on the claim that indicates the test was purchased.

3060.5 Payment to Supplier of Diagnostic Tests for Purchased Interpretations. A person or entity that provides diagnostic tests may submit the claim, and (if assignment is accepted) receive the Part B payment, for diagnostic test interpretations which that person or entity purchases from an independent physician or medical group if:

o The tests are initiated by a physician or medical group which is independent of the person or entity providing the tests and of the physician or medical group providing the interpretations;

o The physician or medical group providing the interpretations does not see the patient.

o The purchaser (or employee, partner, or owner of the purchaser) performs the technical component of the test. The interpreting physician must be enrolled in the Medicare program. No formal reassignment is necessary.

The purchaser must keep on file the name, the provider identification number and address of the interpreting physician. The rules permitting claims by a facility or clinic for services of an independent contractor physician on the physical premises of the facility or clinic are set forth in §§3060.2 and 3060.3C.

3060.6 Payment Under Reciprocal Billing Arrangements.--

A. General.--The patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) which the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis, if:

o The regular physician is unavailable to provide the visit services;

o The Medicare patient has arranged or seeks to receive the visit services from the regular physician;

o The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days; and

o The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering in item 24d of Form CMS-1500 HCPCS Q5 modifier (service furnished by a substitute physician under a reciprocal billing arrangement) after the

o The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering in item 24d of Form CMS-1500 HCPCS Q5 modifier (service furnished by a substitute physician under a reciprocal billing arrangement) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering his/her unique physician identification number (UPIN) on the form

and cross-referring the entry to the appropriate service line item(s) by number(s). Until further notice, the regular physician must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available to you upon request.

If the only substitution services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services.

A physician may have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

B. Definitions.--

1. Covered Visit Service.--The term "covered visit service" includes not only those services ordinarily characterized as a covered physician visit, but also any other covered items and services furnished by the substitute physician or by others as incident to his/her services.

Items and services furnished by the staff of the substitute physician covered as incident to his/her services if billed by him/her are still covered if billed by the regular physician under this section.

Items and services furnished by the staff of the regular physician covered as incident to his/her services if furnished under his/her supervision are still covered if furnished under the supervision of the substitute physician.

2. Continuous Period of Covered Visit Services.--A continuous period of covered visit services begins with the first day on which the substitute physician provides covered visit services to Medicare Part B patients of the regular physician, and it ends with the last day on which the substitute physician provides these services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician or are furnished by some other substitute physician on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

EXAMPLE: The regular physician goes on vacation on June 30, 1992, and returns to work on September 4, 1992. A substitute physician provides services to Medicare Part B patients of the regular physician on July 2, 1992, and at various times thereafter, including August 30th and September 2, 1992. The continuous period of covered visit services begins on July 2nd and runs through September 2nd, a period of 63 days. Since the September 2nd services are furnished after the expiration of 60 days of the period, the regular physician is not entitled to bill and receive direct payment for them. The substitute physician must bill for these services in his/her own name. The regular physician may, however, bill and receive payment for the services which the substitute physician provides on his/her behalf in the period July 2nd through August 30th.

C. Unassigned Claims Under Reciprocal Billing Arrangements.--The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

D. Medical Group Claims Under Reciprocal Billing Arrangements.--The requirements of this section generally do not apply to the substitution arrangements among physicians in the same medical group where claims are submitted in the name of the group. On claims submitted by the group, the group physician who actually performed the service must be identified in the manner described in §3060.9, with one exception. When a group member provides services on behalf of another group member who is the designated attending physician for a hospice patient, the Q5

modifier may be used by the designated attending physician to bill for services related to a hospice patient's terminal illness that were performed by another group member.

For a medical group to submit assigned and unassigned claims for the covered visit services of a substitute physician who is not a member of the group, the requirements of subsection A must be met. The medical group must enter in item 24d of Form CMS-1500 the HCPCS modifier Q5 after the procedure code. Until further notice, the medical group must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available to you upon request. In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) in block 24k of the appropriate line item.

For an independent physician to submit assigned and unassigned claims for the substitution services of a physician who is a member of a medical group, the requirements of subsection A must be met. The independent physician must enter in item 24 of Form CMS-1500 HCPCS modifier Q5 after the procedure code. Until further notice, the independent physician must keep on file a record of each service provided by the substitute medical group physician, associated with the substitute physician's UPIN, and make this record available to you upon request.

Physicians who are members of a group but who bill in their own names are treated as independent physicians for purposes of applying the requirements of this section.

E. Guidance to Physicians--Inform physicians of the requirements of this section. Advise physicians and, if necessary, remind them that, in entering the code Q5 modifier, the regular physician (or the medical group, where applicable) is certifying that the services are covered visit services furnished by the substitute physician identified in a record of the regular physician which is available for inspection, and are services for which the regular physician (or group) is entitled under this section to submit the claim. Mention the possible penalties under subsection F for false certifications.

F. Penalties.--A physician or other person who falsely certifies that the requirements of this section are met may be subject to possible civil and criminal penalties for fraud. Also, the physician's right to receive payment or to submit claims under this section or even to accept any assignments may be revoked. The revocation procedures are set forth in §14025.

G. Claims Review.--If a line item includes the code Q5 certification, assume that the claim meets the requirements of this section in the absence of evidence to the contrary. You need not track the 60-day period or validate the billing arrangement on a prepayment basis, absent postpayment findings which indicate that the certifications by a particular physician may not be valid.

H. Payment Amount.--When you make Part B payment under this section, you determine the payment amount as though the regular physician or his/her staff provided the services. The identification of the substitute physician is primarily for purposes of providing an audit trail to verify that the services were furnished, not for purposes of the payment or the limiting charge. Also, notices of noncoverage under §§7300ff. and 7330ff. are to be given in the name of the regular physician.

3060.7 Payment Under Locum Tenens Arrangements.--

A. Background.--It is a longstanding and widespread practice for physicians to retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the substitute physician's services as though he/she performed them himself/herself. The substitute physician generally has no practice of his/her own and moves from area to area as needed. The regular physician generally pays the substitute physician a fixed amount per diem, with the substitute physician having the status of an independent

contractor rather than of an employee. These substitute physicians are generally called "locum tenens" physicians.

Section 125(b) of the Social Security Act Amendments of 1994 makes this procedure available on a permanent basis. Thus, beginning January 1, 1995, a regular physician may bill for the services of Alocum tenens@ physicians. A regular physician is the physician that is normally scheduled to see a patient. Thus, a regular physician may include physician specialists (such as, a cardiologist, oncologist, urologist, etc.).

B. Payment Procedure--A patient's regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment, for covered visit services (including emergency visits and related services) of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices, if:

- o The regular physician is unavailable to provide the visit services;
- o The Medicare beneficiary has arranged or seeks to receive the visit services from the regular physician;
- o The regular physician pays the locum tenens for his/her services on a per diem or similar fee-for-time basis;
- o The substitute physician does not provide the visit services to Medicare patients over a continuous period of longer than 60 days; and
- o The regular physician identifies the services as substitute physician services meeting the requirements of this section by entering HCPCS Q6 modifier (service furnished by a locum tenens physician) after the procedure code. When Form CMS-1500 is next revised, provision will be made to identify the substitute physician by entering his/her unique physician identification number (UPIN) to you upon request.

See §3060.6B for definitions of covered visit services and continuous period of covered visit services.

If the only substitution services a physician performs in connection with an operation are post-operative services furnished during the period covered by the global fee, these services need not be identified on the claim as substitution services.

C. Unassigned Claims Under Locum Tenens Arrangements.--The requirements for the submission of claims under reciprocal billing arrangements are the same for assigned and unassigned claims.

D. Medical Group Claims Under Locum Tenens Arrangements.--For a medical group to submit assigned and unassigned claims for the services a locum tenens physician provides for patients of the regular physician who is a member of the group, the requirements of subsection B must be met. For purposes of these requirements, per diem or similar fee-for-time compensation which the group pays the locum tenens physician is considered paid by the regular physician. Also, a physician who has left the group and for whom the group has engaged a locum tenens physician as a temporary replacement may still be considered a member of the group until a permanent replacement is obtained. The group must enter in item 24d of Form CMS-1500 the HCPCS Q6 modifier after the procedure code. Until further notice, the group must keep on file a record of each service provided by the substitute physician, associated with the substitute physician's UPIN, and make this record available to you upon request. In addition, the medical group physician for whom the substitution services are furnished must be identified by his/her provider identification number (PIN) on block 24k of the appropriate line item.

Physicians who are members of a group but who bill in their own names are generally treated as independent physicians for purposes of applying the requirements of subsection A for payment for locum tenens physician services. Compensation paid by the group to the locum tenens physician is considered paid by the regular physician for purposes of those requirements. The term "regular physician" includes a physician who has left the group and for whom the group has hired the locum tenens physician as a replacement.

E. Guidance to Physicians, Penalties, Claims Review and Payment Amount.--In regard to guidance for physicians, possible penalties, claims review, and payment amounts, proceed as in §3060.6.

3060.8 Establishing That Person or Entity Qualifies to Receive Payment on Basis of Reassignment.--

A. General.--A person or entity wishing to receive Part B payment as a reassignee of one or more physicians (or other suppliers), or as the supplier of the services, must furnish to the carrier sufficient information to establish clearly that it qualifies to receive payment for those services. Where there is any doubt that the person or entity qualifies, obtain additional evidence.

In some cases, an entity may qualify to receive payment for the services of a physician on the basis of one or more of the exceptions listed in §3060. As soon as it is determined that an organization can qualify on any basis, no further development may be needed for that physician or for other physicians having the same status. However, where some other physicians have or appear to have different status, further development is required. In some cases a determination is made that Part B payment can be made only to the physician himself/herself.

Subject to the provisions of §§7102-7103.1, a reassignee assumes liability for any overpayments which it receives and should be so advised.

B. Payment to Special Accounts.--Sometimes a major institution, such as a medical school or university, may want the Medicare checks due it for physician services to go into particular specialty accounts (or funds, or so-called group practices) which are subdivisions of the institution, and may ask that these accounts be identified on their Medicare checks for internal accounting purposes.

Ideally, to indicate the subordinate nature of the account in relation to the institution, list the name of the institution first on the check, followed by the name of the appropriate account. However, identifying the payee in this manner, your system might cause serious claims processing difficulties, fostering confusion between various accounts of the same institution. To avoid this problem, you may list the name of the account first, followed by the name of the institution, e.g., Radiology Fund, General Medical Center, if the institution submits a letter to you accepting responsibility for any claims submitted, and payments made, under the special designations. The letter needs to describe the special designations the institution wants on the checks for the various accounts and include a statement to the following effect:

> "The (name of institution) accepts the same responsibility for the Medicare claims and payments made under these special designations as it would have if the payments were made by Medicare in the name of (name of institution) without these special designations."

This statement is required in addition to the statement the institution submits to establish its right to receive payment for the physicians' services.

If the above procedure is used as a basis for Part B payments in the names of departments, specialties, or similar subdivisions of a university or medical school or an associated nonprofit foundation or teaching hospital, each subdivision may also execute, or refrain from executing, a participation agreement for physician services in that subdivision. This is an exception to the rule that a participation agreement may only be executed by a person or legal entity. This exception

applies only in the medical school or university medical center context.

3060.9 Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment.--Except where otherwise noted, the following procedures apply to both assigned and unassigned claims submitted by hospitals, medical groups, and other entities entitled to bill and receive payment for physician services under §§3060-3060.3. They are used whether the charges are compensation related or non-compensation related.

A. General.--A hospital, medical group, or other entity entitled to bill and receive payment for physician services uses Form CMS-1500 to submit claims to Medicare. A single claim form may contain services furnished to the same patient by different physicians associated with the same entity. The name and address of the entity is entered in block 33 of Form CMS-1500 and an authorized official of the entity signs in block 31. This official need not be a physician. (See §3055.1 for machine billing and §3057B for a summary of physician and supplier signature requirements.)

B. Provider Identification Numbers.--Assign a provider identification number (group number) to the hospital, medical group, or other entity as a whole. The entity's identification number is entered in block 33. Each physician who performs services for a patient must be identified on Form CMS-1500 in block 24k for the appropriate line item in accordance with Part 4, §2010.2. (When an entity bills for an independent substitute physician under a reciprocal or locum tenens billing arrangement, the performing physicians is the physician member of the entity for whom the substitute is providing services.)

C. Payment Records.--Where the charges by a hospital, medical group, or other entity differ depending on the individual treating physician, transmit the performing physician's UPIN on your Common Working File (CWF) claim record. Where the charges by a hospital, medical group, or other entity are uniform regardless of the individual performing physician, claims records are prepared by entity and entity identification numbers rather than by individual physician and individual physician identification numbers. Show code 70 as specialty code on claims records where such entity's physicians have mixed (more than one) specialties. Where all the physicians associated with such entity have the same specialty, the code used reflects the specialty, e.g., code 30 for a group of radiologists, code 11 for a group of internists. (See §13030.)

D. Outpatient Physical Therapy or Speech Pathology Claims.--Clinics that have been certified to provide outpatient physical therapy or speech pathology services to outpatients also use Form CMS-1500 for billing the Part B carrier. (See §§4160ff.)

3060.10 Payment to Agent.--

A. Conditions.--You may make payment in the name of the physician (or other supplier or party eligible to receive the payment under §3060B, as an employer, facility, or organized health care delivery system) to an agent who furnishes billing or collection services if:

- The agent receives the payment under an agency agreement with the physician;
- The agent's compensation is not related in any way to the dollar amounts billed or collected;
- The agent's compensation is not dependent on the actual collection of payment;
- The agent acts under payment disposition instructions which the physician may modify or revoke at any time; and

o In receiving the payment, the agent acts only on behalf of the physician (except insofar as the agent uses part of that payment to compensate the agent for the agent's billing and collection services).

B. Background.--The primary purpose of this exception to the prohibition in §3060A is to permit computer and other billing services to claim and receive Medicare payment in the name of a physician (or other supplier or eligible party). The conditions for payment are designed to insure that the billing agent has no financial interest in how much is billed or collected and is not acting on behalf of someone who has such an interest, other than the physician himself/herself.

The conditions specified in subsection A do not apply if the agent merely prepares bills for the physician and does not negotiate the checks payable to the physician.

The conditions specified in subsection A also do not apply where the entity receiving payment in the name of the physician qualifies to receive payment in its own name for the physician's services. Thus, a hospital which is entitled to bill and receive payment in its name for a physician's service under §3060.2 may bill and receive payment in the physician's name (negotiating the checks under a power of attorney) even though its compensation is related to the amount billed or collected or is dependent on collection.

C. Documentation.--If payment is being made or is requested to be made in the name of a physician to an agent, you may assume that the conditions for such payment are met in the absence of evidence to the contrary. If there is evidence to the contrary, the agent must document the agency agreement by submitting to the carrier a copy of the written agreement between him/her and the physician (or other supplier or eligible party) if such a written agreement exists. The written agreement may be a formal legal document or merely an exchange of correspondence between the parties. If there is no written agreement of either a formal or informal nature or all the required conditions for payment are not clear in the agreement, obtain a statement from the agent describing the pertinent terms of the agreement or of those specified provisions which need to be clarified. Verify the agent's allegations by obtaining statements from one or more of the physicians who have entered into the agreement with the agent.

3060.11 Payment to Bank.--Absent a court order, Medicare payments due a physician (or other supplier) may be sent to a bank (or similar financial institution) for deposit in the physician's account only if the check is drawn in the name of the physician and the physician certifies that he/she will continue this payment arrangement in effect only so long as the following requirements are met:

o The bank is neither providing financing to the physician nor acting on the behalf of another party in connection with the provision of such financing; and

o The physician has sole control of the account and the bank is subject only to the physician's instructions regarding the account. (Thus, if the bank is under a standing order from the physician to transfer funds from the physician's account to the account of a financing entity in the same or another bank and the physician rescinds that order, the bank honors this rescission notwithstanding the fact that it is a breach of the physician's agreement with the financing entity.)

Subject to the above restrictions on the bank and to the bank's meeting the conditions specified in §3060.10, a bank which is the billing agent for the physician and receives and deposits in the physician's account the physician's Medicare payments may draw on these funds to reimburse itself for its billing services.

Subject to the above restrictions on the bank, a billing agent, other than the bank, that meets the conditions specified in §3060.10 and receives and deposits in the physician's bank account the physician's Medicare payments may draw on these funds to reimburse itself for its billing services.

3060.12 Correcting Unacceptable Payment Arrangements.--

A. Disseminating Information.--From time to time, disseminate through professional relations media information regarding the prohibition in §3060. The following language may be used or adapted for this purpose:

"The Medicare law prohibits us from paying benefits due a physician or other supplier of health care items and services, to another person or organization, under a reassignment or power of attorney or under any other arrangement whereby that other person or organization receives those payments directly. There are the following exceptions to this rule:

o We may pay a physician's or supplier's employer under the terms of his/her employment.

o We may pay a hospital, clinic, or other facility for services furnished by the physician or supplier in the facility, in accordance with the physician's or supplier's agreement with the facility.

o We may pay a group practice prepayment plan, prepaid health plan, or HMO for services of physicians and suppliers associated with the plan.

o We may pay a physician or medical group for purchased diagnostic tests (other than clinical diagnostic tests).

o We may pay a supplier of diagnostic tests for interpretations purchased from a physician or medical group that did not initiate the tests.

o We may pay the patient's regular physician for services provided to his/her patients by another physician on an occasional, reciprocal basis.

o At least until December 31, 1993, we may pay the patient's regular physician for services of a locum tenens physician during the absence of the regular physician where the regular physician pays the locum tenens on a per diem or similar fee-for-time basis.

o We may pay a physician's or supplier's benefits in his/her name to a billing or collection agent, e.g., a medical bureau, if:

- The agent receives the payment under an agency agreement with the physician or supplier;

- The agent's compensation is not related in any way to the dollar amounts billed or collected;

- The agent's compensation is not dependent upon the actual collection of payment;

- The agent acts under instructions which the physician or supplier may modify or revoke at any time; and

- The agent, in receiving the payment, acts only on the physician's or supplier's behalf.

o We may pay a physician's or supplier's benefits in accordance with a reassignment established by, or pursuant to the order of, a court of competent jurisdiction. A physician or supplier should notify us immediately if:

o We have been mailing his/her benefits to the address of another person or organization;

o He/she has given that other person or organization power of attorney or other advance authority to negotiate his/her benefit checks; and

3100. JURISDICTION OF REQUESTS FOR PAYMENT

Medicare carriers typically process Part B fee-for-service claims for covered services furnished in specific geographic areas (e.g., Florida) or for particular Medicare enrollees (e.g., railroad retirement beneficiaries), or for specific types of covered services (e.g., Durable Medical Equipment). (See §2312.3 for claims for Part B medical services performed outside the U.S., for individuals who reside in the U.S.) The rules for determining jurisdiction are the same whether a claim is assigned or nonassigned.

Since the status of a qualified railroad retirement beneficiary may change, carrier jurisdiction may also change. When a carrier receives a Common Working File (CWF) response showing it has jurisdiction but a later CWF response shows that the railroad carrier now has jurisdiction (code 46), the carrier should follow the instructions in §3110. This is true even when the carrier originally receiving the claim may have reason to believe that the jurisdiction has changed again. When a change in jurisdiction occurs, CMS will automatically notify the local and railroad carrier of the change. See §6130.2 for further information involving qualified railroad retirement beneficiaries.

A nonparticipating skilled nursing facility (SNF) is considered a supplier and its claims are submitted to the appropriate carrier on the Form CMS-1500. (See § 2255 and 3115.)

3100.1 Payment Jurisdiction for Services Paid Under the Physician Fee Schedule and Anesthesia Services.--The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the zip code. (See §15012 and §15018.) Though a number of additional services appear on the MPFS database, these payment jurisdiction rules apply only to those services actually paid under the MPFS and to anesthesia services. (For example, it does not apply to clinical lab, ambulance or drug claims.)

Effective for claims received on or after April 1, 2004, carriers must use the zip code of the location where the service was rendered to determine carrier jurisdiction over the claim and the correct payment locality. When a physician or supplier furnishes physician fee schedule services in payment localities that span more than one carrier's service area, separate claims must be submitted to the appropriate area carrier for processing. For example, when a physician with an office in Illinois furnishes services outside the office setting (e.g., home, hospital, SNF visits) and that out of office service location is in another carrier's service area (e.g., Indiana), the carrier which processes physician fee schedule claims for the payment locality where the out of office service was furnished has jurisdiction for that service as it is the carrier with the correct physician fee schedule pricing data for the location where the service was furnished. In the majority of cases, the physician fee schedule services provided by physicians are within the same carrier jurisdiction that the physician's office(s) is/are located.

In states with multiple physician fee schedule pricing localities, or where a provider has multiple offices located in two or more states, or there is more than one carrier servicing a particular state, physicians, suppliers and group practices with multiple offices in such areas must identify the specific location where office-based services were performed to insure correct claim processing jurisdiction and/or correct pricing of MPFS services. Ensure that multiple office situations are cross-referenced within your system

Physicians, suppliers and group practices that furnish physician fee schedule services at more than one office/practice location may submit their claims through one office to the carrier for processing. However, the specific location where the services were furnished must be entered on the claim so that you will have the zip code, can determine the correct claims processing jurisdiction, and can apply the correct physician fee schedule amount. This applies to all places of service except "home." Use the address on the beneficiary files when place of service (POS) is home - 12, or any other mechanism currently in place to determine pricing locality when POS is home - 12.

3100.2 Claims Processing Instructions for Payment Jurisdiction for Claims Received on or after April 1, 2004.--Provided below are separate instructions for processing electronic and paper claims. See §§3060.4 and 3100.3 for additional information on purchased tests.

A. Electronic Claims.--Please note that the following instructions do not apply to services rendered at POS home -12. For services rendered at POS home –12, use the address on the beneficiary file (or wherever else the beneficiary information is currently being stored) to determine pricing locality. (See §3100.1.)

Per the implementation guide of the 4010/4010A1 version of the ASC X12N 837, it is acceptable for claims to contain the code for POS home and any number of additional POS codes. If different POS codes are used for services on the claim, a corresponding service facility location and address must be entered for each service at the line level, if that location is different from the billing provider, pay-to provider, or claim level service facility location. Pay the service based on the zip code of the service facility location, billing provider address, or pay-to provider address depending upon which information is provided.

Refer to the current implementation guide of the ASC X12N 837 to determine how information concerning where a service was rendered, the service facility location, must be entered on a claim. Per the documentation, though an address may not appear in the loop named "service facility address," the information may still be available on the claim in a related loop.

For example:

- On version 4010/4010A of the ASC X12N 837 electronic claim format, the Billing Provider loop 2010AA is required and therefore must always be entered. If the Pay-To Provider Name and Address loop 2010AB is the same as the Billing Provider, only the Billing Provider will be entered. If no Pay-To Provider Name and Address is entered in loop 2010AB, and the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider, then only the Billing Provider will be entered. In this case, price the service based on the Billing Provider zip code.

- If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) will be entered. Price the service based on the zip code in Service Facility Location loop 2310D, unless the 2420C (line level) is also entered. In that case, price the service based on the zip code in the Service Facility Location loop 2420C (line level) for that line.

Make any necessary accommodations in claims processing systems to accept either the header level or line level information as appropriate and process the claims accordingly. No longer use the provider address on file when the POS is office to determine pricing locality and jurisdiction. Appropriate information from the claim must always be used.

In the following situation, per the information in the 4010/4010A1 version of the ASC X12N 837, the place where the service was rendered cannot be identified from the claim. In this situation, price all services on the claim based on the zip code in the Billing Provider loop. Continue to take this action until such time as the ASC documentation is revised to allow for identification of where the service was rendered to be identified from the claim.

If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider or the Pay-To Provider, no entry is required per version 4010/4010A1 for Service Facility Location loop 2310D (claim level) or 2420C (line level).

When the same POS code and same service location address is applicable to each service line on the claim, the service facility location name and address must be entered at the claim level loop 2310D.

In general, when the service facility location name and address is entered only at the claim level, use the zip code of that address to determine pricing locality for each of the services on the claim. When entered at the line level, the zip code for each line must be used.

If the POS code is the same for all services, but the services were provided at different addresses, each service must be submitted with line level information. This will provide a zip code to price each service on the claim.

B. Paper Claims Submitted on the Form CMS-1500.-- Note that the following instructions do not apply to services rendered at POS home - 12. (See §3100.1.)

It is acceptable for claims to contain POS home and an additional POS code. No service address for POS home needs to be entered for the service rendered at POS home in this situation as the address will be drawn from the beneficiary file (or wherever else the carrier is currently storing the beneficiary information) and the information on the claim will apply to the other POS.

- The provider must submit separate claims for each POS. The specific location where the services were furnished must be entered on the claim. Use the zip code of the address entered in Item 32 to price the claim. If multiple POS codes are submitted on the same claim, treat assigned claims as unprocessable and follow the instructions in §3005ff. Carriers must continue to follow their current procedures for handling unprocessable unassigned claims.

  Use the following messages:

  Remittance Advice – Adjustment Reason Code 16 – Claims/service lacks information which is needed for adjudication, and Remark Code –M77 – Incomplete/invalid place of service(s).

  MSN) - 9.2, This item or service was denied because information required to make payment was missing.

If you receive a fee-for-service claim containing one or more services for which the MPFS payment locality is in another carrier's jurisdiction, handle in accordance with the instructions in §3110ff. If you receive a significant volume or experience repeated incidences of misdirected Medicare Physician Fee Schedule claims/services from a particular provider, an educational contact may be warranted. Handle misdirected claims/services for HMO enrollees in accordance with §4267.1.

3100.3 Payment Jurisdiction for Purchased Services.--Diagnostic tests and their interpretations are paid on the MPFS. Therefore, they are subject to the same jurisdictional payment rules as all other services paid on the MPFS. Additional explanation is provided here due to general confusion concerning these services when they are purchased and then billed, rather than rendered and billed by the billing entity. As for any other services, suppliers must also meet current enrollment criteria as stated in Chapter 10 of the Program Integrity Manual in order to be able to enroll and bill for purchased tests and interpretations. That these services are purchased does not negate the need for appropriate enrollment procedures with the carrier that has jurisdiction over the geographic area where the services were rendered. Carriers must follow the instructions in §3110ff if they receive claims for services outside their jurisdiction.

Effective for claim processed on or after April1, 2004, in order to allow the carrier to determine jurisdiction, price correctly, and apply the purchase price limitations, global billing will not be accepted for purchased services on electronic or paper claims. Claims received with global billings in this situation will be treated as unprocessable per §3005.

A. Payment Jurisdiction for Suppliers of Diagnostic Tests for Purchased Interpretations.--Per §3060.5, suppliers may receive payment for purchased interpretations. The purchased interpretation must be billed to the carrier that has jurisdiction over the geographic location where the interpretation was performed. Therefore, suppliers must enroll with the carrier that has jurisdiction over the geographic location where the purchased interpretation was performed (i.e., the supplier must submit the interpretation service component to the carrier that would be billed by the interpreting physician if the interpretation hadn't been purchased).

B. Payment Jurisdiction for Physicians for Purchased Diagnostic Tests.--Per §3060.4, physicians may receive payment for purchased diagnostic tests. However, they must bill that test to the carrier that has jurisdiction over the geographic location where the test was performed. Therefore, physicians must enroll with the carrier that has jurisdiction over the geographic location where the test was performed (i.e., the carrier that would be billed by the test supplier if the test component hadn't been purchased).

3100.4 Payment Jurisdiction for Reassigned Services.--Though a supplier or provider may reassign payment for his services to another entity, that does not negate the necessity of billing the correct carrier for those services when they are services paid under the MPFS. The entity that will be billing for the services must still bill the carrier that has jurisdiction over the geographic area where the services were rendered. Suppliers and providers must also meet current enrollment criteria as stated in Chapter 10 of the Program Integrity Manual in order to be able to enroll and bill for reassigned services.

3100.5 Jurisdiction for Shipboard Services--

1. Services performed by an American physician aboard an American vessel are covered as physician's services where:

(a) The vessel is of American registry;

(b) The physician is duly registered with the Coast Guard to render the professional services in question (see §§2020.1ff for the definition of "physician"); and

(c) The services are rendered while the ship is within the territorial waters of the United States. (See §2312 for the definition of "territorial waters" and of the term "United States.")

Except in the case of a Canadian ship's physician who furnishes emergency services in Canadian waters under the conditions in §2312.2C, a foreign physician who practices medicine on board any foreign vessel cannot be considered a "physician" under the Medicare law and, consequently, any services he renders on board ship are not covered under Medicare even though the services were legally rendered within the "United States."

2. Jurisdiction of claims for shipboard services is determined by the following rules:

(a) Ship Physician's Office in the United States.--The carrier serving the physician's office in the United States always has jurisdiction. The physician's office can include the home office of the shipping line in the United States if the physician customarily bills from that office.

(b) Ship Physician's Office Outside of the United States.--When the physician's office is outside of the United States, jurisdiction is determined as follows:

(I) The carrier serving the final port of debarkation has jurisdiction if the beneficiary's trip terminates in the United States;

(II) The carrier serving the port of embarkation has jurisdiction if the beneficiary's trip terminates in the United States;

The carrier having jurisdiction for a claim for services performed aboard ship has jurisdiction for the entire claim regardless of whether the beneficiary's trip included territorial waters of more than one State or other United States entity or whether or not only portions of the claim may be paid.

3100.6 Exceptions to Jurisdictional Payment--

1. A claim for covered services performed in the United States by a legally authorized Canadian or Mexican physician is within the jurisdiction of the carrier servicing the location where the services were rendered.

2. Requests for payment by individuals who reside in the United States for Part B services performed outside the United States, Canada, or Mexico are within the jurisdiction of the carrier servicing the geographic area in which the claimant resides. Claims for services to residents of the United States that are performed in Canada or Mexico are within the jurisdiction of the appropriate carrier designated in §2312.3. (If the request is for payment of medical services performed outside the United States by a physician or supplier whose office is located in the United States, the carrier servicing the physician's or supplier's office has jurisdiction. This carrier issues the denial determination and handles any resultant appeal.)

3. If a claim by an individual who resides outside the United States involves both medical services provided within the United States and medical services provided outside the United States, the carrier will process both segments of the claim.

3102. AREA CARRIER-SUPPLIER'S SERVICES

A. Suppliers of Durable Medical Equipment, Prosthetics, Orthotics and Supplies.--Most of the claims processing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is handled by four specialized carriers. The claims processing jurisdiction among these carriers is established by the beneficiary's permanent address. A beneficiary's permanent address is determined by where the beneficiary resides for more than 6 months of a year.

For foreign claims ONLY (claims for eligible Medicare beneficiaries living outside of the United States) DMERC claims processing jurisdiction is based on where the service/item was rendered.

Below is a list of the four durable medical equipment regional carriers (DMERCs), and the areas they serve. All claims for DMEPOS, other than implanted durable medical equipment and implanted prosthetic devices, should be sent to the appropriate DMERC. All claims for implanted durable medical equipment and implanted prosthetic devices, as well as DMEPOS items incident to a physician's service, should be sent to the appropriate local carrier.

DMERC A
United HealthCare
60 East Main St.
Nanticoke, PA 18634
(Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New York, New Jersey, Pennsylvania, Rhode Island, Vermont)

DMERC B
AdminaStar Federal, Inc.
8115 Knue Rd.
Indianapolis, IN 46250
(District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio,Virginia, West Virginia, Wisconsin)

DMERC C

Palmetto Government Benefits Administrators
P.O. Box 100141
Suite 500
Columbia, SC 29202-3141
(Alabama, Arkansas, Colorado, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands)

DMERC D

CIGNA
P.O. Box 690
Nashville, TN 37202
(Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming)

B. Supplier of Portable X-Ray, EKG or Similar Portable Services.--If a supplier operates mobile units in geographic areas served by more than one carrier, the claims must be processed by the carrier serving the area where the service was performed.

C. Ambulance Service Which Exceeds Covered Limits.--Where the ambulance trip exceeds covered limits (see§2120.3), reimbursement is limited to the amount which would have been paid for a trip from the point of pick-up to the nearest appropriate facility or, in the other direction, from the nearest appropriate facility to the patient's place of residence. (See §2125.)

In those situations in which several vehicles (including air ambulance) are utilized during a single trip in the moving of the patient, all bills and claim data must be available to the carrier with jurisdiction over the claim. Of course, no ambulance claim in which the service exceeds the covered limits can be adjudicated without knowing the starting point, the final destination of the patient, as well as information as to all vehicles used to transport the patient.

Where any information is necessary to prepare a payment or disallowance action the carrier must obtain the information from the claimant or the supplier concerned. This could include contacting a carrier in another State or another locality to obtain certification or rate information, etc.

Where the partial reimbursement rule applies, the jurisdiction of the claim is based on whether only one ambulance vehicle or multiple vehicles were used.

1. One Ambulance Vehicle Used.--If only one vehicle is used to transport the patient from the point of initial pickup to the final destination, jurisdiction is with the carrier serving the point of origin, i.e., home station of the vehicle. This carrier has qualification information on the ambulance supplier and in most cases all other pertinent details necessary to adjudicate a claim.

EXAMPLE: A patient is picked up at the Johns Hopkins Hospital in Baltimore, Maryland and transported to his home in West Virginia by an ambulance dispatched from the area of the patient's home. The carrier serving the point of origin of the ambulance--Nationwide Mutual Insurance Company, Part B carrier for the State of West Virginia, has jurisdiction of any claim filed. In this case Nationwide should have all the data necessary to make proper payment, i.e., certification of the ambulance company, price information and data pertaining to the nearest appropriate company, price information and data pertaining to the nearest appropriate facility. Had an ambulance whose home station was in Baltimore been used, the carrier servicing Baltimore, Maryland would have had

jurisdiction. The Baltimore carrier would then have had to obtain data concerning the nearest appropriate facility to the patient's home from Nationwide.

2. More Than One Vehicle Used.--If more than one vehicle is used in transporting the patient to his or her destination, under the partial reimbursement rule, jurisdiction of the claim lies with:

a. The carrier serving the home base of the ambulance taking the patient on the first leg of the trip, on a trip to a distant institution more remote than the nearest appropriate facility; or The carrier serving the home base of the ambulance taking the patient on the final leg of his or her trip home, on a trip from an institution more remote than the nearest appropriate facility.

If there is no claim for the final leg of the trip, the carrier serving the patient's home area handles any resulting claims or disallowance actions.

EXAMPLE: A patient is transported by ambulance from a hospital in Miami Beach, Florida to Miami International Airport and from there by air ambulance to LaGuardia Airport in Queens, New York City. At the airport he is picked up by an ambulance (based in Yonkers, New York) and taken to his home in Yonkers, New York. The carrier which handles the adjudication is the carrier whose area of reimbursement is based upon the nearest appropriate facility to his residence when he is being returned home from a distant institution.

In rules 1 and 2 above the principle followed is that the carrier having the information to determine the nearest appropriate facility is the one to adjudicate the claim. In any event, before any partial reimbursement can be made, the carriers as designated in rules 1 and 2, must have all the information concerning the patient's transportation, from initial pickup to final destination.

D. Independent Laboratories.--Jurisdiction of payment requests for laboratory services furnished by an independent laboratory, except where indicated below, lies with the carrier serving the area in which the laboratory test is performed. Jurisdiction is not affected by whether or not the laboratory uses a central billing office and whether or not the laboratory provides services to customers outside its carrier's service area.

EXHIBIT 10-DATA ELEMENT REQUIREMENTS MATRIX

CLAIMS WILL BE RETURNED AS UNPROCESSABLE IF THE FOLLOWING INFORMATION IS INCOMPLETE/INVALID

CMS 1500	NSF 3.01	ANSI 837 Version 4010	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	MedicareStatus (Required or Conditional for EDI) *
1A	DA0 - 18.0	Loop 2010BA 2-015-NM109	Insured I.D. Number	Subscriber Primary Identifier	R
2	CA0 - 04.0	Loop 2010BA 2-015-NM103	Patient Name	Subscriber Last Name	R
	CA0 - 05.0	Loop 2010BA 2-015-NM104		Subscriber First Name	R
4	DA0 - 19.0	Loop 2330A 2-325-NM103	Insured Name	Other Insured Last Name	C
	DA0 - 20.0	Loop 2330A 2-325-NM104		Other Insured First Name	C
6	DA0 - 17.0	Loop 2000B 2-005-SBR02 Loop 2320 2-290-SBR02	Patient Relationship to Insured	Individual Relationship Code	C
7	DA2 – 04.0	Loop 2330A 2-332-N301	Insured's Address	Other Insured Address Line 1	C
	DA2 – 06.0	Loop 2330A 2-340-N401		Other Insured City	C
	DA2 - 07.0	Loop 2330A 2-340-N402		Other Insured State	C
	DA2 - 08.0 Loop 2330A 2-340-N403			Other Insured Zip Code	C
	DA2 - 09.0	Not Used	Insured Telephone Number		NR
8	CA0 - 17.0	Not Used	Patient Status		NR
	CA0 - 18.0	Not Used	Patient Student Status		NR
	CA0 - 19.0	Not Used	Patient Employment Status		NR
11	DA0 - 10.0	Loop 2320 2-290-SBR03	Insured's Policy Group Number	Insured Group or Policy Number	C
	DA0 - 05.0	Loop 2320 2-290-SBR09		Claim Filing Indicator Code	C**
	DA0 - 06.0	Loop 2320 2-290-SBR05		Insurance Type Code	C
11C	DA0 - 11.0	Loop 2320 2-290-SBR04	Insurance Plan or Program Name	Other Insured Group Name	C
12	DA0 - 16.0	Loop 2300 2-130-CLM10	Patient Signature Source	Patient Signature Source Code	C
	EA0 - 13.0	Loop 2300 2-130-CLM09		Release of Information Indicator	R
14	EA0 - 07.0	Loop 2300 2-135-DTP03(439)	Date of Current Illness, etc.	Accident Date	C
	GC0 - 05.0	Loop 2300 2-135-DTP03(454) OR Loop 2400 2-455-DTP03(454)		Initial Treatment Date	C
15	EA0 - 15.0	Not Used	Patient Has Same/Similar Illness	Same/Similar Symptom Indicator	NR
	EA0 - 16.0	Loop 2300 2-135-DTP03(438) OR Loop 2400 2-455-DTP03(438)		Onset of Similar Symptoms or Illness	C
		Loop 2300 2-135-DTP03(431) OR Loop 2400 2-455-DTP03(431)	Date of current illness or injury	Onset of current illness or injury	C
17	EA0 - 24.0	Loop 2310A 2-250-NM103 OR Loop 2420F 2-500-NM103	Name of Referring Provider	Referring Provider Last Name	C
	EA0 – 25.0	Loop 2310A 2-250-NM104 OR Loop 2420F 2-500-NM104		Referring Provider First Name	C
			OR		
	FB1 - 06.0	Loop 2420E 2-500-NM103		Ordering Provider Last Name	C
	FB1 - 07.0	Loop 2420E 2-500-NM104		Ordering Provider First Name	C
			OR		
17A	FB1 - 09.0	Loop 2420E 2-525-REF02(1G)	I.D. Number of Referring Physician	Ordering Provider Secondary Identifier (UPIN)	C
			OR		
	FB0 - 09.0	Loop 2420E 2-500-NM109(24 or 34)		Order Provider Primary Identifier (SSN or EIN)	C
			OR		
	EA0 - 20.0	Loop 2310A 2-250-NM109(24 or 34) OR Loop 2420F 2-500-NM109(24 or 34)		Referring Provider Primary Identifier (SSN or EIN)	C
			OR		
	EA0 - 21.0 OR FB1 – 13.0	Loop 2310A 2-271-REF02(1G) Loop 2420F 2-525-REF02(1G)		Referring Provider Secondary Identifier (UPIN)	C

EXHIBIT 10-DATA ELEMENT REQUIREMENTS MATRIX

CLAIMS WILL BE RETURNED AS UNPROCESSABLE IF THE FOLLOWING INFORMATION IS INCOMPLETE/INVALID

CMS 1500	NSF 3.01	ANSI 837 Version 4010	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	MedicareStatus (Required or Conditional for EDI) *
19	EA1 - 16.0	Loop 2310E 2-250-NM109 OR Loop 2420D 2-500-NM109	Reserved for Local Use	Supervising Provider Primary Identifier (UPIN)	C
	FB1 - 21.0	Loop 2310E 2-271-REF02(1G) OR Loop 2420D-2-525-REF02(1G)		Supervising Provider Secondary Identifier (PIN)	C
	GC0 - 06.0	Loop 2300 2-135-DTP03(455) OR Loop 2400 2-455-DTP03(455)		X-Ray Date	C
	EA0 – 48.0	Loop 2300 2-135-DTP03(304) OR Loop 2400 2-455-DTP03(304)		Date Last Seen	C
	EA0 - 50.0	Loop 2300 2-220-CRC03(IH)		Homebound Indicator	C
	EA1 - 25.0	Loop 2300 2-135-DTP03(090/091)		Assumed and Relinquished Care Dates	C
	FA0 - 40.0	Loop 2400 2-450-CRC02(70)		Hospice Employed Provider Indicator	C
20	FB0 - 05.0	Loop 2400 2-488-PS102	Outside Lab	Purchased Service Charge	C
21	EA0 - 32.0	Loop 2300 2-231-HI01-02(BK)	Diagnosis	Principal Diagnosis Code	C
	EA0 - 33.0	Loop 2300 2-231-HI02-02(BF)		Diagnosis Code	C
	EA0 - 34.0	Loop 2300 2-231-HI03-02(BF)		Diagnosis Code	C
	EA0 - 35.0	Loop 2300 2-231-HI04-02(BF)		Diagnosis Code	C
22			Medicaid Resubmission Code		NR
23	DA0 - 14.0	Loop 2300 2-180-REF02(G1) OR Loop 2400 2-470-REF02(G1)	Prior Authorization Number	Prior Authorization or Referral Number	C
	FA0 - 34.0	Loop 2300 2-180-REF02(X4) OR Loop 2400 2-470-REF02(X4)	CLIA ID Number	CLIA Certification Number	C
	EA0 - 53.0	Loop 2310D 2-271-REF02(LU)	Care Plan Oversight (CPO) Number	CPO Number	C
	EA0 - 54.0	Loop 2300 2-180-REF02(LX)		Investigational Device Number	C
24A	FA0 - 05.0	Loop 2400 2-455-DTP03(472)	Dates of Service (s) (From date)	Service Date	R
	FA0 - 06.0	Loop 2400 2-455-DTP03(472)	Dates of Service (s) (To Date)	Service Date	C
24B	FA0 - 07.0	Loop 2300 2-130-CLM05-1 OR Loop 2400 2-370-SV105	Place of Service	Facility Type Code Place of Service Code	R
24C	FA0 - 08.0	Not Used	Type of Service	Type of Service Code	NR
24D	FA0 - 09.0	Loop 2400 2-370-SV101-2 (HC)	Procedures, Services, etc.	Procedure Code	R
	FA0 - 10.0	Loop 2400 2-370-SV101-3		Procedure Modifier 1	C
	FA0 - 11.0	Loop 2400 2-370-SV101-4		Procedure Modifier 2	C
	FA0 - 12.0	Loop 2400 2-370-SV101-5		Procedure Modifier 3	C
	FA0 - 36.0	Loop 2400 2-370-SV101-6		Procedure Modifier 4	C
24G	FA0 - 18.0	Loop 2400 2-370-SV104 (UN)	Days or Units of Service OR	Units of Service	R
	FA0 - 19.0	Loop 2400 2-370-SV104 (MJ)		Anesthesia/Oxygen Minutes	R
24H	FB0 - 22.0	Loop 2400 2-370-SV112	EPSDT Family Plan	Family Planning Indicator	NR
24I	FA0 - 20.0	Loop 2400 2-370-SV109	EMG	Emergency Indicator	NR
24J	FB0 - 21.0	Loop 2400 2-370-SV115	COB	Co-pay Status Code	NR
24K	FA0 - 23.0	Loop 2310B 2-250-NM109(24 or 34) OR Loop 2420A 2-500-NM109(24 or 34)	Reserved for Local Use	Rendering Provider Primary Identifier (SSN or EIN)	C
	BA0 - 09.0	Loop 2310B 2-271-REF02(1C) OR Loop 2420A 2-525-REF02(1C)		Rendering Provider Secondary Identifier (PIN)	C
27	EA0 - 36.0	Loop 2300 2-130-CLM07	Accept Assignment	Medicare Assignment Code	R
31	EA0 - 37.0	Loop 2300 2-130-CLM06	Provider Signature Indicator	Provider or Supplier Signature Indicator	R

EXHIBIT 10-DATA ELEMENT REQUIREMENTS MATRIX

CLAIMS WILL BE RETURNED AS UNPROCESSABLE IF THE FOLLOWING INFORMATION IS INCOMPLETE/INVALID

CMS 1500	NSF 3.01	ANSI 837 Version 4010	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	MedicareStatus (Required or Conditional for EDI) *
32	EA0 - 39.0	Loop 2310D 2-250-NM103	Facility Name and Address	Laboratory or Facility Name	C
				AND/OR	
	EA1 - 04.0	Loop 2310D 2-250-NM109(24 or 32) OR Loop 2420C 2-500-NM109(24 or 32)		Laboratory or Facility Primary Identifier (SSN or EIN)	C
		Loop 2310D 2-271-REF02(1C) OR Loop 2420C 2-525-REF02(1C)	OR	Laboratory or Facility Secondary Identifier (SSN or EIN)	
	FB0 - 11.0	Loop 2310C 2-250-NM109(24 or 34) OR Loop 2400 2-488-PS101		Purchased Service Provider Primary Identifier (SSN or EIN)	C
		Loop 2310C 2-271-REF02(1C) OR Loop 2400 2-488-PS101 OR Loop 2420B 2-525-REF02(1C)		Purchased Service Provider Secondary Identifier (PIN)	
	FA0 - 31.0	Loop 2300 2-180-REF02(EW) OR Loop 2400 2-470-REF02(EW)		Mammography Certification Number	C
33	BA0 - 19.0	Loop 2010AA 2-015-NM103(85,1)	Provider's Billing Name & Address	Provider Last Name	R
	BA0 - 20.0	Loop 2010AA or 2010AB 2-015-NM104		Provider First Name	R
			OR	OR	
	BA0 - 18.0	Loop 2010AA or 2010AB 2-015-NM103(85,2)		Payer Organization Name	R
	BA1 - 13.0	Loop 2010AA or 2010AB 2-025-N301		Pay-To Provider Address 1	R
	BA1 - 15.0	Loop 2010AA or 2010AB 2-030-N401		Pay-To Provider City Name	R
	BA1 - 16.0	Loop 2010AA or 2010AB 2-030-N402		Pay-To Provider State Code	R
	BA1 - 17.0	Loop 2010AA or 2010AB 2-030-N403		Pay-To Provider Zip Code	R
	BA1 - 18.0	Loop 2010AA 2-040-PER04		Communication Number	C
			OR		
	BA0 - 09.0 BA0 - 02.0	Loop 2010AA or 2010AB 2-015-NM109(24 or 34)	Provider's Billing Name & Address	Billing Provider Primary Identifier (SSN or EIN)	R
	CA0 - 28.0	Loop 2010AA or 2010AB 2-035-REF02(1C)		Billing Provider Secondary Identifier (PIN)	C

* R = Required - information which MUST always be on a claim.
* C = Conditional - information which is required on a claim if certain conditions exist.
NR = Not Required - information which is either optional or is not required in order to process a claim.
**Required prior to mandated use of PlanID. Not used after Plan ID is mandated.

Item 19. The 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN 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.)

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

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.

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.

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.)

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.

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, the specific surgery for which the exam is being performed.

The specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.
The 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 and/or relinquished date

Enter the pin (or UPIN when effective) of the physician who is performing a purchased interpretation of a diagnostic test (see MCM Part 3 §3060.5) for additional information.

Item 20. This item is completed when billing for diagnostic tests subject to purchase price limitations. The purchase price under charges must be shown 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 service facility locations. (See §3060.4.)

Item 21. The patient's diagnosis/condition. All physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition). An independent laboratory 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. The professional review organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

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.

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

Item 24a. The 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 C.

Item 24b. The appropriate place of service code(s) from the list provided in §4020.3. 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 Carriers must place the correct type of service indicator that matched the HCPCS procedure code, see §4020.G.

Item 24d. The procedures, services, or supplies using the Health Care Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.

The specific procedure code must be shown 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. The diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Only one reference number per line item. When multiple services are performed, the primary reference number for each service; either a 1, or a 2, or a 3, or a 4 is shown.

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

Item 24f. The charge for each listed service.

Item 24g. 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, the actual number provided must be indicated.

For anesthesia, the provider must indicate 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.

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

Items 24k. 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. The 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. The patient's account number assigned by the provider of service's 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. The appropriate block must be checked 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. Total charges for the services (i.e., total of all charges in item 24f).

Item 29. Total amount the patient paid on the covered services only.

Item 30. Leave blank. Not required by Medicare.

Item 31. The signature of the practitioner 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. The name, 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 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.

Effective for claims received on or after April1, 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 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 HCFA-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, the supplier must 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. The practitioner's/supplier's billing name, address, zip code, and telephone number. The PIN for the performing provider of service/supplier who is not a member of a group practice. Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this field.

The group PIN for the performing practitioner/supplier who is a member of a group practice.