Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1665

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4020.1 (Cont.) - 4020.2 (Cont.)	4-19 - 4-20 (2 pp.)	4-19 - 4-20 (2 pp.)
4020.2 (Cont.) - 4020.2 (Cont.)	4-20.3 - 4-20.6 (4 pp.)	4-20.3 - 4-20.6 (4pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: August 20, 2001*
IMPLEMENTATION DATE: August 20, 2001

Section 4020, Review of Health Insurance Claim Form HCFA-1500, is revised to correct the following items on Form HCFA-1500: Item 10a thru 10c, the word **must** is being deleted from the first sentence. Items 19, 24k, 32, and 33 the word "UPIN" is being replaced with "PIN".

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.

Item 9d. The 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then the Medigap insurance program or plan name is shown.

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

Items 10a thru 10c .Check YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. The State postal code must be shown. Any item checked "YES" indicates there may be other insurance primary to Medicare. Primary insurance information must then be shown in item 11.

Item 10d. Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, this item must show the patient's Medicaid number preceded by MCD.

Item 11. THIS ITEM MUST BE COMPLETED. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare, enter the insured's policy or group number is entered and then proceed to items 11a - 11c.

NOTE: The appropriate information in item 11c is shown if insurance primary to Medicare is indicated in item 11.

If there is no insurance primary to Medicare, the word "NONE" is used and then proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), the word “NONE” is shown and proceed to item 11b.

Insurance Primary to Medicare.--Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage:
  - -- Working aged;
  - -- Disability (large group health plan); and
  - -- End Stage Renal Disease;
- No Fault and/or Other Liability; and
- Work-Related Illness/Injury:
  - -- Workers' compensation;
  - -- Black lung; and
  - -- Veterans benefits.

NOTE: For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payers explanation of benefits (EOB) notice must be forwarded along with the claim form.

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

Item 11b. Employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word "RETIRED."

Item 11c. The 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the complete primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB.

Item 11d. Leave blank. Not required by Medicare.

Item 12. The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alphanumeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with §§3047.1 - 3047.3, Part 3 of MCM. If the patient is physically or mentally unable to sign, a representative specified in §3008, Part 3 of MCM may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless patient or the patient's representative revokes this arrangement.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X). When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13. The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item, or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

4020.2 Items 14-33 - Physician or Supplier Information.--

Item 14. The patient's 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date of current illness, injury, or pregnancy. For chiropractic services, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date of the initial treatment or exacerbation of the existing condition.

Item 15. Leave blank. Not required by Medicare.

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

Item 17. The name of the referring or ordering physician must be shown if the service or item was ordered or referred by a physician.

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

The statement, "Attending physician, not hospice employee" when a physician renders services to a hospice patient but the hospice providing the patient's care (in which the patient resides) does not employ the attending physician.

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

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, each test must be submitted on a separate claim form.

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.

If a physician performs a service on a SNF patient outside of a SNF, the physician must enter the SNF's Medicare provider number.

At such time as SNF consolidated billing becomes effective when physicians provide services to a beneficiary residing in a SNF and the services where rendered to a SNF beneficiary outside of the SNF, the physician should enter the Medicare facility provider number of the SNF in Item 23.

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 HCFA Common 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:

- 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.

- 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.

- 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.

Item 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 HCFA-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 and address and zip code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. When the name, address and zip code of the facility where the services were furnished is the same as the billers name, address and zip code shown in item 33, enter the word "SAME." 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 HCFA-1500 should be used to bill for each supplier.

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. However, if the address shown in item 33 is in a HPSA and is the same as where the services were rendered, enter the word "SAME."

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, including the 2-digit location identifier must be indicated.

Item 33. The practitioner's/supplier's billing name, address, zip code, and telephone number. The PIN, including the 2-digit location identifier, 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, including the 2-digit location identifier, for the performing practitioner/supplier who is a member of a group practice.