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 1409

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - Chapter IV	4-1 - 4-2 (2 pp.)	4-1 - 4-2 (2 pp.)
4020.1 - 4020.4 (Cont.)	4-17 - 4-20.15 (19 pp.)	4-18 - 4-20.10 (24 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: January 29, 2001*
IMPLEMENTATION DATE: January 29, 2001

Section 4020.1, Items 1–13 – Patient and Insured Information, updates to match Cariers Manual Professional Relations Part 4.

Section 4020.2, Items 14-33 – Physician or Supplier Information, updates to match Carriers Manual Professional Relations Part 4.

Section 4020.3, Place of Service Codes (POS) and Definitions, updates to match Carriers Manual Professional Relations Part 4.

Section 4020.4, Exhibits, updates to match Carriers Manual Professional Relations Part 4.

Section 4020.5, Item 24, has been **deleted.**

Section 4020.6, Items 25-33, has been **deleted.**

Section 4021, Simplified Billing Requirements for Independent Laboratory Claims, has been **deleted.**

Section 4022, Review of Relevant Information, has been **deleted.**

Section 4025, Time Limit for Filing Claims, has been **deleted.**

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 IV
CLAIMS REVIEW AND ADJUDICATION PROCEDURES

Section

Line Review - Form HCFA-l490S

Line Review - Health Insurance Claim Form

Items and Services Having Special Review Considerations

4020. REVIEW OF HEALTH INSURANCE CLAIM FORM - HCFA-1500

HCFA-1500 (Health Insurance Claims Form) answers the needs of many health insurers. It is the basic form prescribed by HCFA for the Medicare and Medicaid programs for claims submitted by physicians and suppliers, except for ambulance services. It has also been adopted by CHAMPUS and has the approval of the AMA Council on Medical Services.

There are a number of Part B services that have special limitations on payments or that require special methods of benefit computation.

Monitor your processing systems to insure that you recognize the procedure codes that involve services with special payment limitations or calculation requirements. Be able to identify separately billed procedure codes for physician services which are actually part of a global procedure code to prevent payment more than if the procedure were billed globally. (See §5248.) Periodically review your internal instructional material and the actual manner in which claims are coded and paid. Conduct such a review at least annually. The following must be completed or are required for a Medicare claim. Provide information on completing the HCFA-1500 to all physicians and suppliers in your area at least once a year.

4020.1 Items 1-13 - Patient and Insured Information--

Item 1. Enter the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

Item 1a. The patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer.

Item 2. The patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card.

Item 3. The patient's 8-digit birth date (MM | DD | CCYY) and sex.

Item 4. If the patient has insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5. The patient's mailing address and telephone number. The first line is for the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6. The patient's relationship to insured when item 4 is completed.

Item 7. The insured's address and telephone number. When the address is the same as the patient's, use the word SAME. Complete this item only when items 4 and 11 are completed.

Item 8. The patient's marital status and whether employed or a student.

Item 9. The last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, use the word SAME. If no Medigap benefits are assigned, leave blank. This field may be used in the future for supplemental insurance plans.

NOTE: ONLY PARTICIPATING PHYSICIANS AND SUPPLIERS ARE TO COMPLETE ITEM 9 AND ITS SUBDIVISIONS AND ONLY WHEN THE PATIENT WISHES TO ASSIGN HIS/HER BENEFITS UNDER A MEDIGAP POLICY TO THE PARTICIPATING PHYSICIAN OR SUPPLIER.

Participating physicians and suppliers enter information required in item 9 and its subdivisions if requested by the patient. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a patient elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.

Medigap.--A Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of Title XVIII of the Social Security Act and the definition contained in the NAIC Model Regulation which is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item 9a. The policy and/or group number of the Medigap insured preceded by **MEDIGAP, MG, or MGAP**.

NOTE: Item 9d must be completed if a policy and/or group number is in item 9a.

Item 9b. The Medigap insured's 8-digit birth date (MMDDCCYY) and sex.

Item 9c. Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, the claims processing address of the Medigap insurer is shown. Use an abbreviated street address, two letter postal code, and zip code copied from the Medigap insured's Medigap identification card. For example:

1257 Anywhere Street
Baltimore, MD 21204

is shown as "1257 Anywhere St MD 21204."

Item 9d. 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. "YES" or "NO" must be checked 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 ued 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 benfits (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.

Referring physician is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician is a physician who orders non-physician services for the patient such as diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, or durable medical equipment.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Social Security Act. All claims for Medicare covered services and items that are the result of a physician's order or referral must include the ordering/referring physician's name and Unique Physician Identificaiton Number (UPIN). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- o Diagnostic laboratory services;
- o Diagnostic radiology services;
- o Consultative services; and
- o Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list must also show the ordering/referring physician's name and UPIN. For example, a surgeon must complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services must obtain an UPIN even though they may never bill Medicare directly. A physician who has not been assigned an UPIN must contact the Medicare carrier.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN of the physician supervising the limited licensed practitioner must appear in items 17 and 17a.

When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.

Enter the original ordering/referring physician's name and UPIN in items 17 and 17a of the first claim form.

Enter the ordering (performing) physician's name and UPIN in items 17 and 17a of the second claim form.

Surrogate UPINs.--If the ordering/referring physician has not been assigned an UPIN, one of the surrogate UPINs listed below must be used in item 17a. The surrogate UPIN used depends on the circumstances and is used only until the physician is assigned an UPIN. Enter the physician's name in item 17 and the surrogate UPIN in item 17a. All surrogate UPINs, with the exception of retired physicians (RET00000), are temporary and may be used only until an UPIN is assigned. You must monitor claims with surrogate UPINs.

The term "physician" when used within the meaning of §1861(r) of the Social Security Act and used in connection with performing any function or action, refers to:

(1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

(2) A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

(3) A doctor of podiatric medicine for purposes of subsections (k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

(4) A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

(5) A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine to correct a subluxation. For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Item 17a. The HCFA assigned UPIN of the referring/ordering physician listed in item 17. Enter only the 7-digit base number and the 1-digit check digit.

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

Use the following surrogate UPINs for physicians who have not been assigned individual UPINs. Claims received with surrogate numbers will be tracked and possibly audited.

- Residents who are issued an UPIN in conjunction with activities outside of their residency status must use that UPIN. For interns and residents without UPINs, use the eight (8) character surrogate UPIN RES00000;

- Retired physicians who were not issued an UPIN may use the surrogate RET00000;

- Physicians serving in the Department of Veterans Affairs or the U.S. Armed Services may use VAD00000;

- Physicians serving in the Public Health or Indian Health Services may use PHS00000;

- When the ordering/referring physician has not been assigned an UPIN and does not meet the criteria for using one of the surrogate UPINs, the biller may use the surrogate UPIN "OTH00000" until an individual UPIN is assigned.

- Effective for claims with dates of service on or after July 1, 2000, the UPIN must be entered in Item 17a for hepatitits B claims.

Item 18. The 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

Item 19. 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 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 relinguished 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.

Items 24k. The UPIN 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 UPIN 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 practioner 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 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 and address of the facility where the services were furnished is the same as the billers name and address shown in item 33, enter the word "SAME." Providers of service (namely physicians) must identify the supplier's name, address, and UPIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate 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.

At such time as SNF consolidated billing becomes effective, when physicians provide services to a beneficiary residing in a SNF and the SNF is the location where the services were rendered (Place of Service Code 31), the SNF Medicare facility provider number should be entered in Item 32.

Item 33. The practioner's/supplier's billing name, address, zip code, and telephone number. The UPIN, including the 2-digit location identifier, for the performing provider of service/supplier who is not a member of a group practice.

The group UPIN, including the 2-digit location identifier, for the performing practioner/supplier who is a member of a group practice.

4020.3 Place of Service Codes (POS) and Definitions. --

A. New Place of Service Codes.--The new HCFA-1500 POS codes, as well as a crosswalk to the "old" HCFA-1500 POS codes, are listed below. The current CWF POS codes are identical to those of the new HCFA-1500.

New HCFA-1500 (12/90)		Old HCFA-1500
00-10	Unassigned	
11	Office	3 - (O)
12	Home	4 - (H)
13-20	Unassigned	
21	Inpatient Hospital	1 - (IH)
22	Outpatient Hospital	2 - (OH)
23	Emergency Room - Hospital	2 - (OH)
24	Ambulatory Surgical Center	B - (ASC)
25	Birthing Center	0 - (OL)
26	Military Treatment Facility	0 - (OL)
27-30	Unassigned	
31	Skilled Nursing Facility	8 - (SNF)
32	Nursing Facility	7 - (NH)
33	Custodial Care Facility	0 - (OL)
34	Hospice	0 - (OL)
35-40	Unassigned	
41	Ambulance	Land
42	Ambulance	Air or Water
43-49	Unassigned	
50	Federally Qualified Health Center	
51	Inpatient Psychiatric Facility	0 - (OL)
52	Psychiatric Facility Partial Hospitalization	
53	Community Mental Health Center	
54	Intermediate Care Facility/ Mentally Retarded	D - (STF)
55	Residential Substance Abuse Treatment Facility	C - (RTC)
56	Psychiatric Residential Treatment Center	C - (RTC)
57-59	Unassigned	
60	Mass Immunization Center	
61	Comprehensive Inpatient Rehabilitation Facility	0 - (OL)
62	Comprehensive Outpatient Rehabilitation Facility	E - (COR)
63-64	Unassigned	
65	End-Stage Renal Disease Treatment Facility	F - (KDC)
66-70	Unassigned	
71	State or Local Public Health Clinic	0 - (OL)
72	Rural Health Clinic	0 - (OL)

New HCFA-1500 (12/90)		Old HCFA-1500
73-80	Unassigned	
81	Independent Laboratory	A - (IL)
82-98	Unassigned	
99	Other Unlisted Facility	

B. Place of Service.--Following are the approved definitions for places of service.

o Inpatient Hospital.--A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical) and rehabilitation services by or under the supervision of physicians to patients admitted for a variety of medical conditions.

o Outpatient Hospital.--A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

o Emergency Room - Hospital.--A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.

o Skilled Nursing Facility (SNF).--A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

o Nursing Facility (NF).--A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.

o Custodial Care Facility.--A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.

o Ambulatory Surgical Center (ASC).--A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

o Hospice.--A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.

o Patient's Home.--Location, other than a hospital, or other facility, where the patient receives care in a private residence.

o Office.--Location, other than a hospital, SNF, or ICF, where the health professional routinely provides health examinations, diagnosis and treatment of illness or injury on an ambulatory basis.

o Psychiatric Facility Partial Hospitalization.--A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full-time hospitalization, but who need broader programs than are possible from outpatient visits in a hospital-based or hospital-affiliated facility.

o Inpatient Psychiatric Facility.--A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

o Independent Laboratory.--A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

o Comprehensive Outpatient Rehabilitation Facility (CORF).--A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.

o Comprehensive Inpatient Rehabilitation Facility.--A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.

o End Stage Renal Disease Treatment Facility.--A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or care givers on an ambulatory or home-care basis.

o Ambulance Land.--A land vehicle specifically designed, equipped, or staffed for lifesaving and transporting the sick or injured.

o Ambulance Air or Water.--An air or water vehicle specifically designed, equipped or staffed for lifesaving and transporting the sick or injured.

o Rural Health Clinic (RHC).--A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.

o State or Local Public Health Clinic.--A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.

o Community Mental Health Care (CMHC).--A facility that provides comprehensive mental health services on an ambulatory basis primarily to individuals residing or employed in a defined area.

o Other Unlisted Facility.--Other service facilities not identified above.

o Birthing Center.--A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.

o Military Treatment Facility (MTF).--A medical facility operated by one or more of the Uniformed Services. MTF also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).

o Intermediate Care Facility/Mentally Retarded.--A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals, but does not provide the level of care or treatment available in a hospital or skilled nursing facility (SNF).

o Residential Substance Abuse Treatment Facility.--A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

o Psychiatric Residential Treatment Center.--A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

o Mass Immunization Center.--A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting. (See §4480.8.)

o Federally Qualified Health Center.--A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.

If the physician bills for lab services performed in his/her office, the code for "Office" is shown. If the physician bills for a lab test furnished by another physician, who maintains a lab in his/her office, the code for "Other" is shown. If the physician bills for a lab service furnished by an independent lab, the code for "Independent Laboratory" is used. Items 21 and 22 on the HCFA-1500 must be completed for all laboratory work performed outside a physician's office. If an independent lab bills, the place where the sample was taken is shown. An independent laboratory taking a sample in its laboratory shows "IL" as place of service. If an independent laboratory bills for a test on a sample drawn on a hospital inpatient, it uses the code for "Hospital Inpatient".

For hospital visits by physicians, presume, in the absence of evidence to the contrary, that visits billed for were made. However, review a sample of physician's records when there are questionable patterns of utilization. Confirm these visits where the medical facts do not support the frequency of the physician's visits or in cases of beneficiary complaints.

If questioning whether the visit had been made, ascertain whether the physician's own entry is in the patient's record at the provider. Accept an entry where the nurses' notes indicate that the physician saw the patient on a given day. A statement by the beneficiary is also acceptable documentation if it was made close to the alleged date of the visit. Entries in the physician's records represent possible secondary evidence. However, these are of less value since they are self-serving statements. Exercise judgment regarding their authenticity. The policy requiring daily physician visits is not conclusive if, in the individual case, the facts did not support a finding that daily visits were made.

If place of service is missing, then edit and review claims for missing place of service information. If the place of service is missing but you can infer the place of service from the procedure code billed (e.g., the procedure code billed is site specific (e.g., visit codes)), then append/plug the place of service that is compatible with the procedure code for both assigned and nonassigned services and continue processing the line item.

If the place of service is missing and you cannot infer the place of service from the procedure code billed (e.g., a procedure code for which the definition is not site specific or which can be performed in more than one setting), then return assigned services as unprocessable and develop for the place of service on nonassigned claims.

If place of service is inconsistent with procedure code billed, then edit for consistency or compatibility between the place of service and site-specific procedure codes. If the place of service is valid but inconsistent or incompatible with the procedure billed (e.g., the place of service is inpatient hospital and the procedure code billed is office visit), then return assigned services as unprocessable and develop nonassigned services since you typically will not know whether the procedure code or the place of service is incorrect in such instances.

If place of service is invalid, then edit for the validity of the place of service coding. If the place of service code is not valid (e.g., the number designation has not been assigned or defined by HCFA),

then return assigned services as unprocessable and develop for a valid place of service on nonassigned line items.

C. Type of Service (TOS).--For submitting a claim to the Common Working File (CWF), use the following table to assign the proper TOS. Some procedures may have more than one applicable TOS. For claims received on or after April 3, 1995, CWF will produce alerts on codes with incorrect TOS designations. Effective July 3, 1995, CWF is rejecting codes with incorrect TOS designations. The only exceptions to this table are:

- Surgical services billed with the ASC facility service modifier SG must be reported as TOS F. The indicator F does not appear on the TOS table because its use is dependent upon the use of the SG modifier.

- Surgical services billed with an assistant-at-surgery modifier (80-82, AS,) must be reported with TOS 8. The 8 indicator does not appear on the TOS table because its use is dependent upon the use of the appropriate modifier. See §15044 for instructions on when assistant-at-surgery is allowable.

- Psychiatric treatment services that are subject to the outpatient mental health treatment limitation should be reported with TOS T. (See §2470.3.)

- TOS H appears in the list of descriptors. However, it does not appear in the table. In CWF, "H" is used only as an indicator for hospice. You should not submit TOS H to CWF at this time.

- When these specific transfusion medicine codes appear on the claim (86880, 86885, 86886, 86900, 86903, 86904, 86905, and 86906 that also contains a blood product (P9010-P9022)), the transfusion medicine codes are paid under reasonable charge. When these services are to be paid under reasonable charge, use TOS 1. When paid under reasonable charge, tests are paid at 80 percent. Coinsurance and deductible also apply.

NOTE: For injection codes with more than one possible TOS designation, use the following guidelines when assigning the TOS:

When the choice is L or 1,

- Use TOS L when the drug is used related to ESRD; and

- Use TOS 1 when the drug is not related to ESRD and is administered in the office.

When the choice is G or 1:

- Use TOS G when the drug is an immunosuppressive drug; and

- Use TOS 1 when the drug is used for other than immunosuppressivon.

When the choice is P or 1,

- Use TOS P if the drug is administered through durable medical equipment (DME); and

- Use TOS 1 if the drug is administered in the office.

You may consider the place of service or diagnosis when determining the appropriate TOS. The descriptors for each of the TOS codes listed in the following table are:

Type of Service Indicators

0 - Whole Blood
1 - Medical Care
2 - Surgery
3 - Consultation
4 - Diagnostic Radiology
5 - Diagnostic Laboratory
6 - Therapeutic Radiology
7 - Anesthesia
8 - Assistant at Surgery
9 - Other Medical Items or Services
A - Used DME
B - High Risk Screening Mammography
C - Low Risk Screening Mammography
D - Ambulance
E - Enteral/Parenteral Nutrients/Supplies
F - Ambulatory Surgical Center (Facility Usage for Surgical Services)
G - Immunosuppressive Drugs
H - Hospice
J - Diabetic Shoes
K - Hearing Items and Services
L - ESRD Supplies
M - Monthly Capitation Payment for Dialysis
N - Kidney Donor
P - Lump Sum Purchase of DME, Prosthetics, Orthotics
Q - Vision Items or Services
R - Rental of DME
S - Surgical Dressings or Other Medical Supplies
T - Outpatient Mental Health Treatment Limitation
U - Occupational Therapy
V - Pneumococcal/Flu Vaccine
W - Physical Therapy

4020.4 Exhibits. --

- Exhibit 1 - Health Insurance Claim Form HCFA-1500;

Exhibit 1

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HEALTH INSURANCE CLAIM FORM (FORM HCFA-1500)

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CONTINUATION OF

HEALTH INSURANCE CLAIM FORM