
CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 148

Date: APRIL 23, 2004

CHANGE REQUEST 3138

I. SUMMARY OF CHANGES: For consistency with other manuals, this change includes non-physician practitioners in the definition of those who may order services. It makes several editorial changes. It describes the way the identity of the supervising physician shall be entered on the Form CMS-1500 paper claim when the service is performed incident to another physician in the same group.

NEW/REVISED MATERIAL - EFFECTIVE DATE: May 24, 2004

***IMPLEMENTATION DATE: May 24, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will only receive the new/revised information, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:

(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	26/10.4 / Items 14-33 - Provider of Service or Supplier Information

*III. FUNDING:

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

*Medicare contractors only

Attachment - Business Requirements

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SUBJECT: Incident-To Services on Form CMS-1500

I. GENERAL INFORMATION

A. Background: The preamble of the proposed rule for the Medicare Physician Fee Schedule on November 1, 2001, (66 **Federal Register**. 55267) stated “the billing number of the ordering physician (or other practitioner) should not be used if that person did not directly supervise the auxiliary personnel.” This transmittal manualizes that rule.

B. Policy: The manual update clarifies where physician’s Provider Information Numbers and names should be reported when both an ordering provider and a supervising provider are involved in a service.

C. Provider Education: A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin.

II. BUSINESS REQUIREMENTS

“Shall” denotes a mandatory requirement

“Should” denotes an optional requirement

Requirement #	Requirements	Responsibility
3138.1	Post or link the provider education article as directed above.	Carrier

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
	N/A

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
	N/A

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

<p>Effective Date: May 24, 2004</p> <p>Implementation Date: May 24, 2004</p> <p>Pre-Implementation Contact(s): Dorothy Shannon, 410-786-3396, Dshannon2@cms.hhs.gov</p> <p>Post-Implementation Contact(s): Dorothy Shannon, 410-786-3396, Dshannon2@cms.hhs.gov</p>	<p>These instructions shall be implemented within your current operating budget.</p>
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10.4 - Items 14-33 - Provider of Service or Supplier Information

(Rev. 148, 04-23-04)

B3-3005.4, B3-4020.2, B4-2010.2; B-03-045; AB-03-091; B-00-15; B-98-28; TR-1712; TR-1718; TR-1819

Reminder: For date fields other than date of birth, all fields *shall* be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.

Item 15 - Leave blank. Not required by Medicare.

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

Item 17 - Enter the name of the referring or ordering physician 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 *or, when appropriate, a non-physician practitioner* who orders nonphysician services for the patient. *See Pub. 100-02, Chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.*

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

- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;

- Consultative services; and
- Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list *shall* also show the ordering/referring physician's name and UPIN (the NPI will be used when implemented). For example, a surgeon *shall* 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 (the NPI will be used when implemented) appear in items 17 and 17a.

When a service is incident to the service of a physician or non-physician practitioner, the name and assigned UPIN (the NPI shall be used when implemented) of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services obtain a UPIN (the NPI will be used when implemented) even though they may never bill Medicare directly. A physician who has not been assigned a UPIN contact the Medicare carrier.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN (the NPI will be used when implemented) of the physician supervising the limited licensed practitioner 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 (the NPI will be used when implemented) in items 17 and 17a of the first claim form.

Enter the ordering (performing) physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).

Surrogate UPINs - If the ordering/referring physician has not been assigned a UPIN (the NPI will be used when implemented), one of the surrogate UPINs listed below be used in item 17a. The surrogate UPIN used depends on the circumstances and is used only until the physician is assigned a 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 a UPIN is assigned. The contractor monitor claims with surrogate UPINs.

The term "physician" when used within the meaning of [§1861\(r\)](#) of the 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 §§(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 - Enter the CMS assigned UPIN (the NPI will be used when implemented) of the referring/ordering physician listed in item 17.

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

Contractors 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 a UPIN in conjunction with activities outside of their residency status use that UPIN. For interns and residents without UPINs, use the 8-character surrogate UPIN RES00000;
- Retired physicians who were not issued a 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;

- The law extends coverage and direct payment in non-Metropolitan Statistical Areas to practitioners who are State licensed to order medical services or refer patients to Medicare providers without the approval or collaboration of a supervising physician. Billers use the surrogate UPIN "UPIN0000" on claims involving services ordered/referred by nurse practitioners, clinical nurse specialists, or any nonphysician practitioner who is State licensed to order clinical diagnostic tests; and
- When the ordering/referring physician has not been assigned a 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.

NOTE: This field is required when a service was ordered or referred by a physician.

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

Item 19 - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the contractor is certifying that all the relevant information requirements (including level of subluxation) of the Medicare Benefits Policy Manual, Chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.

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

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

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

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See the Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Services," and the Claims Processing Manual, Chapter 16, "Laboratory Services," and the Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a participating provider. In this case, no payment may be made on the claim.

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

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

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

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

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

Enter the PIN (or NPI when effective) of the physician who is performing a purchased interpretation of a diagnostic test (see the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," for additional information). Report the interpreting physician's PIN preceded by a "PI" indicator (i.e., PI999999).

NOTE: Item 19 can contain up to three conditions per claim. Additional conditions be reported on a separate Form CMS-1500.

Item 20 - Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 be completed. When billing for multiple purchased diagnostic tests, each test on the Form CMS-1500, each test 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 Chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) 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 enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for nonphysician specialties be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

Item 23 - Enter the Quality Improvement Organization (QIO) prior authorization number for those procedures requiring PRO prior approval.

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

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

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

When a physician provides services to a beneficiary residing in a SNF and the services were rendered to a SNF beneficiary outside of the SNF, the physician should enter the Medicare facility provider number of the SNF in item 23.

A substituting physician under a reciprocal billing or locum tenens arrangement (mandated by statute [§1842\(b\)\(6\)\(D\)](#) of the Act) may be accommodated using item 23. The billing "absentee" physician's Provider Identification Number (PIN) continue to be reported in item 33 under solo practice arrangements and in item 24K under group practice arrangements.

NOTE: Item 23 can contain only one condition. Any additional conditions be reported on a separate Form CMS-1500.

Item 24A - Enter an 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field.

Return as unprocessable if a date of service extends more than one day and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in Section [10.5](#). Identify the location, using a place of service code, for each item used or service performed. This is a required field.

Item 24C - Medicare providers are not required to complete this item.

Item 24D - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code.

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

Return as unprocessable 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.

Item 24E - Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number per line item. When multiple services are performed, enter the primary reference number for each service, either a 1, or a 2, or a 3, or a 4. This is a required field.

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

Item 24F - Enter the charge for each listed service.

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

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

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

Suppliers 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 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 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.

NOTE: This field should contain at least one day or unit. The Carrier should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable.

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 - Enter the PIN (the NPI will be used when implemented) of the performing provider of service/supplier if the provider is 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 *(or NPI when implemented)* in the corresponding line item. **In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN *(or NPI when implemented)* of the supervisor in 24k.**

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

Item 26 - Enter the patient's account number assigned by the provider's of service 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 - Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. If Medigap is indicated in block 9 and Medigap payment authorization is given in item 13, the provider of service or supplier also be a Medicare participating provider of service or supplier and 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:

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- Participating physician/supplier services;
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services; and
- Drugs and biologicals.

Item 28 - Enter total charges for the services (i.e., total of all charges in item 24f).

Item 29 - Enter the total amount the patient paid on the covered services only.

Item 30 - Leave blank. Not required by Medicare.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 - Enter 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. 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.

Effective for claims received on or after April 1, 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 be submitted.

Providers of service (namely physicians) 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, 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 CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in Chapter 1 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.

For durable medical, orthotic, and prosthetic claims, the name address, or PIN of the location where the order was accepted *must* be entered (DMERC only).

This field is required. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

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

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

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

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed, and the PIN, be indicated.

If a physician performs a service (s) in a hospital (Place of Service Codes = 21, 22, 23), the physician enter the Medicare provider number, in addition to name and address. When entering the Medicare provider number, precede each number with HSP. Only one provider number per claim may be billed.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

Enter the UPIN, for the performing provider of service/supplier who is **not** a member of a group practice. This includes the PIN of a billing "absentee" physician in a solo practice.

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

Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this field.