CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1432	**Date: February 1, 2008**
	Change Request 5858

Subject: Medicare Fee For Service Legacy Provider IDs Prohibited on Form CMS-1500 and Form CMS-1450 (UB-04) Claims

I. SUMMARY OF CHANGES: Medicare Fee for Service contractors shall not report Medicare legacy provider identification numbers on Form CMS-1500 and Form CMS-1450 (UB-04) claims. Claims containing legacy provider identification numbers will be returned without appeal rights. References to the former 12-90 version of the Form CMS-1500 have been deleted from the Pub. 100-04 Chapter 26, Section 10.4 manual instructions.

New / Revised Material
Effective Date: May 23, 2008 Effective Date Refers to Date of Claim Receipt

Implementation Date: April 7, 2008

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 receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/80.3.2.1.1/Carrier Data Element Requirements
R	26/10.4/Items 14-33 - Provider of Service or Supplier Information

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1432	Date: February 1, 2008	Change Request: 5858

SUBJECT: Medicare Fee for Service Legacy Provider IDs Prohibited on Form CMS-1500 and Form CMS-1450 (UB-04) Claims

Effective Date: **May 23, 2008. Effective Date Refers to Date of Claim Receipt**

Implementation Date: April 7, 2008

I. GENERAL INFORMATION

A. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required issuance of a unique national provider identifier (NPI) to each physician, supplier, and other provider of health care who conducts HIPAA standard electronic transactions. CMS has made the decision to also require reporting of the NPI on claims submitted by providers in paper claim format on the Form CMS-1500 and Form CMS-1450 (UB-04). CMS began to issue NPIs on May 23, 2005. CMS has been allowing transactions adopted under HIPAA to be submitted with a variety of identifiers. They are:

- NPI only
- Medicare legacy only
- NPI and legacy combination

On April 2, 2007, the Department of Health and Human Services provided guidance to covered entities regarding contingency planning for the implementation of the NPI. As long as a health plan is compliant, meaning they can accept and send NPIs on electronic transactions, they may establish contingency plans to facilitate the compliance of their trading partners. As a compliant health plan, Medicare fee for service (FFS) established a contingency plan on April 20, 2007, that followed this guidance.

B. Policy: Medicare FFS will require transactions to report only an NPI; legacy provider identifier numbers will no longer be permitted on Form CMS-1500 or Form CMS-1450 claims, except in certain situations where an NPI is not required. Claims containing legacy provider identifiers will be returned, without appeal rights.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5858.1	Contractors shall recognize the changes in the Medicare Claims Processing manual, Pub. 100-04, chapter 1, section 80.3.2.1.1	X	X		X			X	X		
5858.1.1	Contractors shall return Form CMS-1500 and Form CMS-1450 (UB-04) claims, without appeal rights, that contain legacy provider identifiers, e.g., PINs, UPINs,	X	X	X	X	X		X	X		

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	or National Supplier Clearinghouse numbers.										
5858.1.1.1	Contractors shall not return claims in certain situations where an NPI is not required (e.g., foreign claims, deceased provider claims, other situations as allowed by CMS in the future) and legacy numbers are reported on the claim. Such claim(s) shall be processed in accordance with established procedures for such claims.	X	X	X	X	X					
5858.1.1.2	Contractors shall use appropriate message(s), such as the following Remittance Advice Remark code, when returning a claim as unprocessable using the remittance process: N257 Missing/incomplete/invalid billing provider primary identifier **NOTE:** CMS is working on developing a more appropriate message for use in returning claims containing legacy provider identifiers. Contractors may use their discretion to choose appropriate message(s).	X	X		X	X		X	X		
5858.2	Contractors that employ a manual process to return claims may continue to use their current process.			X							
5858.3	Contractors shall recognize the changes in the Medicare Claims Processing manual, Pub. 100-04, chapter 26, section 10.4	X	X		X			X	X		
5858.4	Fiscal intermediaries shall continue to recognize chapter 25, section 75.5 of the Medicare Claims Processing Manual, Pub.100-04, for coding instructions.	X		X		X					
5858.5	The Shared Systems shall code effective date logic for full NPI implementation to be flexible.	X	X	X	X	X		X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
5858.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters"	X	X	X	X	X					

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
5858.1.1	FIs should follow their current procedures for returning hardcopy claims to providers that are unprocessable due to missing/incomplete/invalid information.

B. For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Thomas Dorsey, 410-786-7434, Thomas.Dorsey@cms.hhs.gov (Pub.100-04, Chapter 1), Brian Reitz, 410-786-5001, Brian.Reitz@cms.hhs.gov (Pub. 100-04, Chapter 26), Yvonne Young, 410-786-1886, Yvonne.Young@cms.hhs.gov (FI Billing), Susan Webster, 410-786-3384, Susan.Webster@cms.hhs.gov (DME Billing)

Post-Implementation Contact(s): Appropriate CMS Regional Office

VI. FUNDING

A. *For, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*:
The Medicare Administrative Contractor (MAC) is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as changes to the MAC Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described

above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

80.3.2.1.1 - Carrier Data Element Requirements

(Rev.1432, Issued: 02-01-08, Effective: 05-23-08, Implementation: 04-07-08)

A - Required Data Element Requirements

1 - Paper Claims

The following instruction describes certain data element formatting requirements to be followed when reporting the calendar year date for the identified items on the Form CMS-1500:

- If birth dates are furnished in the items stipulated below, then these items must contain 8-digit birth dates (MMDDCCYY). This includes 2-digit months (MM) and days (DD), and 4-digit years (CCYY).

Form CMS-1500 Items Affected by These Reporting Requirements:

Item 3 - Patient's Birth Date

Item 9b - Other Insured's Date of Birth

Item 11a - Insured's Date of Birth

Note that 8-digit birth dates, when provided, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line.

If a birth date is provided in items 3, 9b, or 11a, and is not in 8-digit format, carriers must return the claim as unprocessable. Use remark code N329 on the remittance advice. For formats other than the remittance, use code(s)/messages that are consistent with the above remark codes.

If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b, or 11a. and the birth date is not in 8-digit format. However, if carriers use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

For certain other Form CMS-1500 conditional or required date items (items 11b, 14, 16, 18, 19, or 24A.), when dates are provided, either a 6-digit date or 8-digit date may be provided.

If 8-digit dates are furnished for any of items 11a., 14, 16, 18, 19, or 24A. (excluding items 12 and 31), carriers must note the following:

- All completed date items, except item 24A., must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line;

- Item 24A. must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24A. will penetrate the dotted, vertical lines used to separate month, day, and year. Carrier claims processing systems will be able to process the claim if the date penetrates these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24A;

- Do not compress or change the font of the "year" item in item 24A. to keep the date within the confines of item 24A. If a continuous number is furnished in item 24A. with no spaces between month, day, and year, you will not need to compress the "year" item to remain within the confines of item 24A.;

- The "from" date in item 24A. must not run into the "to" date item, and the "to" date must not run into item 24B.;

- Dates reported in item 24A. must not be reported with a slash between month, day, and year; and

- If the provider of service or supplier decides to enter 8-digit dates for any of items 11b, 14, 16, 18, 19, or 24A. (excluding items 12 and 31), an 8-digit date must be furnished for all completed items. For instance, you cannot enter 8-digit dates for items 11b, 14, 16, 18, 19 (excluding items 12 or 31), and a 6-digit date for item 24A. The same applies to those who wish to submit 6-digit dates for any of these items.

Carriers must return claims as unprocessable if they do not adhere to these requirements.

2 - Electronic Claims

Carriers must return all electronic claims that do not include an 8-digit date (CCYYMMDD) when a date is reported. They use remark code N329 on the remittance advice. For formats other than the remittance, carriers use code(s)/message(s) that are consistent with the above remark codes.

If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b., or 11a. and the birth date is not in 8-digit format. However, if carriers do use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

B - Required Data Element Requirements

The following Medicare-specific, return as unprocessable requirements in this section and the following two sections are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations implementing HIPAA require the use of National Provider Identifiers (NPIs) by covered health care providers and health plans. Although not required by HIPAA, CMS is extending the requirement *to* include the NPI on electronic claims to paper claims submitted on the Form CMS-1500 (8/05). Carriers are referred to the Health Care Claims Professional 837 Implementation guide for requirements for professional claims subject to HIPAA, including the NPI reporting requirements.

Carriers must return a claim as unprocessable to a provider of service or supplier and use the indicated remark code, *or select and use another appropriate remark code*, if the claim is returned through the remittance advice or notice process. In most cases, reason code 16, "Claim/service lacks information that is needed for adjudication", will be used in tandem with the appropriate remark code that specifies the missing information. Carriers *shall return a claim as unprocessable*:

1. If a claim lacks a valid Medicare Health Insurance Claim Number (HICN) in item 1a. or contains an invalid HICN in item 1a. (Remark code MA61.)

2. If a claim lacks a valid patient's last and first name as seen on the patient's Medicare card or contains an invalid patient's last and first name as seen on the patient's Medicare card. (Remark code MA36.)

3. If a claim does not indicate in item 11 whether or not a primary insurer to Medicare exists. (Remark code MA83 or MA92.)

4. If a claim lacks a valid patient or authorized person's signature in item 12 or contains an invalid patient or authorized person's signature in item 12. (See "Exceptions," bullet number one. Remark code MA75.)

5. If a claim lacks a valid "from" date of service in item 24A or contains an invalid "from" date of service in item 24A. (Remark code M52.)

6. If a claim lacks a valid place of service (POS) code in item 24B., or contains an invalid POS *code* in item 24B. return the claim as unprocessable to the provider or supplier, using RA remark code M77. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, if a claim contains more than one POS (other than Home – 12), for services paid under the MPFS and anesthesia services.

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

Note: Level 3 HCPCS *are not valid under HIPAA after Dec 31, 2003.*

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

9. If a claim does not indicate at least 1 day or unit in item 24G (Remark Code M53.) (Note: To avoid returning the claim as "unprocessable" when the information in this item is missing, the carrier must program the system to automatically default to "1" unit).

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

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

a. A billing name, address, ZIP Code, and telephone number of a provider of service or supplier. (Remark code N256 or N258.)

AND EITHER

b. A valid PIN number or, for DMERC claims, a valid National Supplier Clearinghouse number (NPI in item 33a. of the Form CMS-1500 (8/05) when the NPI is required) for the performing provider of service or supplier who is not a member of a group practice. (Remark code N257)

OR

c. A valid group PIN (or NPI when required) number or, for DMERC claims, a valid National Supplier Clearinghouse number (NPI in item 33a. of the Form CMS-1500 (8/05), when the NPI is required) for performing providers of service or suppliers who are members of a group practice. (Remark code N257)

12. If a claim does not contain in Item 33a., Form CMS 1500 (08-05), the NPI, when required, of the billing provider, supplier, or group. (Remark Code N257 or MA112.)

13. Effective May 23, 2008, if a claim contains a legacy provider identifier, e.g., PIN, UPIN, or National Supplier Clearinghouse number. (Remark Code N 257)

NOTE: *Claims are not to be returned as unprocessable in situations where an NPI is not required (e.g., foreign claims, deceased provider claims, other situations as allowed by CMS in the future) and legacy numbers are reported on the claim. Such claims are to be processed in accordance with the established procedures for these claims.*

10.4 - Items 14-33 - Provider of Service or Supplier Information

(Rev.1432, Issued: 02-01-08, Effective: 05-23-08, Implementation: 04-07-08)

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 his/her 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. *All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.*

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 1835of 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.

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 non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, 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. See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;

- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);

- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;

- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

Item 17a – Enter the ID qualifier 1G, followed by the CMS assigned UPIN of the referring/ordering physician listed in item 17. *All physicians who order services or refer Medicare beneficiaries must report this data.*

NOTE: Effective May 23, *2008*, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

Item 17b Form CMS-1500 – Enter the NPI of the referring/ordering physician listed in item 17. *All physicians who order services or refer Medicare beneficiaries must report this data.*

NOTE: Effective May 23, *2008,*17a is not to be reported but 17b MUST be reported 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) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when a physician providing routine foot care submits claims.

For physical therapy, occupational therapy or speech-language pathology services, effective for claims with dates of service on or after June 6, 2005, the date last seen and the UPIN/NPI of an ordering/referring/attending/certifying physician or non-physician practitioner are not required. If this information is submitted voluntarily, it must be correct or it will cause rejection or denial of the claim. However, when the therapy service is provided incident to the services of a physician or nonphysician practitioner, then incident to policies continue to apply. For example, for identification of the ordering physician who provided the initial service, see Item 17 and 17a, and for the identification of the supervisor, see item 24*J* of this section.

NOTE: *Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.*

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 chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is 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 an NOC code if one can be given within the confines of this box. Otherwise an attachment shall 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 Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, 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 non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

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 *NPI/*PIN of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, chapter 1, section 30.2.9.1 for additional information.)

NOTE: *Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.*

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Individuals and entities who bill carriers or A/B MACs for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

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 shall be completed. When billing for multiple purchased diagnostic tests, each test shall be submitted on a separate claim Form CMS-1500. 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 for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall 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 QIO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial. Post Market Approval number should also be placed here when applicable.

For physicians performing care plan oversight services, enter the 6-digit Medicare provider number (or NPI) 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.

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

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 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.

NOTE: When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.

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

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

code modifiers with the HCPCS code. The Form CMS-1500 has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (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 shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (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 provider shall 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.

For instructions on submitting units for oxygen claims, see chapter 20, section 130.6 of this manual.

NOTE: This field should contain at least 1day 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 - Enter the ID qualifier 1C in the shaded portion.

Item 24J - Enter the rendering provider's PIN in the shaded portion. 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 of the supervisor in the shaded portion.

Enter the rendering provider's NPI number in the lower *unshaded* portion. 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 NPI of the supervisor in the lower *unshaded* portion.

NOTE: *Effective May 23, 2008, the shaded portion of 24J is not to be reported.*

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. Medicare providers are not required to complete this item for crossover purposes since the Medicare contractor will retrieve the tax identification information from their internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

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 item 9 and Medigap payment authorization is given in item 13, the provider of service or supplier shall 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;
- Drugs and biologicals; and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

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 alpha-numeric 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, enter 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 shall be submitted.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP Code when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 shall 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 Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in 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 and address 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 shall 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 modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA) or Physician Scarcity Area (PSA), the physical location where the service was rendered shall 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.

Item 32a - If required by Medicare claims processing policy, enter the NPI of the service facility.

Item 32b - If required by Medicare claims processing policy, enter the PIN of the service facility. Be sure to precede the PIN with the ID qualifier of 1C. There should be one blank space between the qualifier and the PIN.

NOTE: *Effective May 23, 2008, Item 32b is not to be reported.*

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

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

Item 33b - Enter the ID qualifier 1C followed by one blank space and then the PIN of the billing provider or group. Suppliers billing the DME MAC will use the National Supplier Clearinghouse (NSC) number in this item.

NOTE: *Effective May 23, 2008, Item 33b is not to be reported.*