CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4205	**Date: January 18, 2019**
	Change Request 11078

SUBJECT: Update to Pub. 100-04 Chapter 15 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating the New Medicare Card Project-related language in Pub 100-04, Chapter 15. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: February 19, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 19, 2019

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/30/30.1.2/Coding Instructions for Paper and Electronic Claim Forms

III. FUNDING:
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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 4205	Date: January 18, 2019	Change Request: 11078

SUBJECT: Update to Pub. 100-04 Chapter 15 to Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: February 19, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 19, 2019

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Pub 100-04, Chapter 15.

B. Policy: The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11078.1	MACs shall be aware of the updated language for the New Medicare Card Project in Pub. 100 - 04, Chapter 15.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov , Kimberly Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual
Chapter 15 - Ambulance

30.1.2 - Coding Instructions for Paper and Electronic Claim Forms
(Rev. 4205, Issued: 01-18-19, Effective: 02-19-19, Implementation: 02-19-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Except as otherwise noted, beginning with dates of service on or after January 1, 2001, the following coding instructions must be used.

Origin

Electronic billers should refer to the Implementation Guide to determine how to report the origin information (e.g., the ZIP Code of the point of pickup). Beginning with the early implementation of version 5010 of the ASC X12 837 professional claim format on January 1, 2011, electronic billers are required to submit, in addition to the loaded ambulance trip's origin information (e.g., the ZIP Code of the point of pickup), the loaded ambulance trip's destination information (e.g., the ZIP code of the point of drop-off). Refer to the appropriate Implementation Guide to determine how to report the destination information. Only the ZIP Code of the point of pickup will be used to adjudicate and price the ambulance claim, not the point of drop-off. However, the point of drop-off is an additional reporting requirement on version 5010 of the ASC X12 837 professional claim format.

Where the CMS-1500 Form is used the ZIP code is reported in item 23. Since the ZIP Code is used for pricing, more than one ambulance service may be reported on the same paper claim for a beneficiary if all points of pickup have the same ZIP Code. Suppliers must prepare a separate paper claim for each trip if the points of pickup are located in different ZIP Codes.

Claims without a ZIP Code in item 23 on the CMS-1500 Form item 23, or with multiple ZIP Codes in item 23, must be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N53
MSN: N/A

ZIP Codes must be edited for validity.

The format for a ZIP Code is five numerics. If a nine-digit ZIP Code is submitted, the last four digits are ignored. If the data submitted in the required field does not match that format, the claim is rejected.

Mileage

Generally, each ambulance trip will require two lines of coding, e.g., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

Beginning with dates of service on or after January 1, 2011, mileage billed must be reported as fractional units in the following situations:

- Where billing is by ASC X12 claims transaction (professional or institutional), and
- Where billing is by CMS-1500 paper form.

Electronic billers should see the appropriate Implementation Guide to determine where to report the fractional units. Item 24G of the Form CMS-1500 paper claim is used.

Fractional units are not required on Form CMS-1450

For trips totaling up to 100 covered miles suppliers must round the total miles up to the nearest tenth of a mile and report the resulting number with the appropriate HCPCS code for ambulance mileage. The decimal must be used in the appropriate place (e.g., 99.9).

For trips totaling 100 covered miles and greater, suppliers must report mileage rounded up to the next whole number mile without the use of a decimal (e.g., 998.5 miles should be reported as 999).

For trips totaling less than 1 mile, enter a "0" before the decimal (e.g., 0.9).

For mileage HCPCS billed on the ASC X12 837 professional transaction or the CMS-1500 paper form only, contractors shall automatically default to "0.1" units when the total mileage units are missing.

Multiple Patients on One Trip

Ambulance suppliers submitting a claim using the ASC X12 professional format or the CMS-1500 paper form for an ambulance transport with more than one patient onboard must use the "GM" modifier ("Multiple Patients on One Ambulance Trip") for each service line item. In addition, suppliers are required to submit documentation to A/B MACs (Part B) to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the *Medicare beneficiary identifiers* for each Medicare beneficiary. A/B/MACs (Part B) shall calculate payment amounts based on policy instructions found in Pub.100-02, Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services, Section 10.3.10 – Multiple Patient Ambulance Transport.

Ambulance claims submitted on or after January 1, 2011, in version 5010 of the ASC X12 837 professional claim format require the presence of a diagnosis code and the absence of diagnosis code will cause the ambulance claim to not be accepted into the claims processing system. The presence of a diagnosis code on an ambulance claim is not required as a condition of ambulance payment policy. The adjudicative process does not take into account the presence (or absence) of a diagnosis code, but a diagnosis code is required on the ASC X12 837 professional claim format.