CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4388	**Date: September 6, 2019**
	Change Request 11331

SUBJECT: Manual Updates to Chapters 1, 22, 24, 26, and 31 in Publication (Pub.) 100-04

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update chapters 1, 22, 24, 26, and 31of Pub. 100-04. Updates include modifying a CMS website link, deleting chapter 22, section 70 (outdated X12 Version 4010 information), updating the CMS Form 1490-S instructions, as well as other minor updates.

EFFECTIVE DATE: October 7, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 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	1/50/50.1/50.1.1/Billing Form as Request for Payment
R	1/70/70.8/70.8.4/Claims Forms CMS-1490S and CMS-1500
R	1/70/70.8/70.8.8.6/Monitoring Claims Submission Violations
R	1/80/80.3/80.3.2/Handling Incomplete or Invalid Claims
R	22/40/40.1/ASC X12 835
R	22/50/50.1/The Do Not Forward (DNF) Initiative
R	22/60/60.2/Claim Adjustment Reason Codes
D	22/70/ASC X12 Version 4010A1
R	24/30/30.1/EDI Enrollment
R	24/50/50.3/50.3.4/Common Edits and Enhancement Module (CEM) Code Sets Requirements
R	24/90/90.1/Small Providers and Full-Time Equivalent Employee Self-Assessments
R	26/Table of Contents
R	26/10/10.4/Items 14-33 - Provider of Service or Supplier Information
R	26/20/Patient’s Request for Medical Payment Form CMS-1490S
R	31/10/10.2/Eligibility Connectivity Workflow

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: 4388	Date: September 6, 2019	Change Request: 11331

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EFFECTIVE DATE: October 7, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019I. GENERAL INFORMATION

A. Background: Modifications are needed to update a CMS website link, to delete chapter 22, section 70 (the Accredited Standards Committee X12 [835] Version 4010A1), to update the CMS Form 1490-S instructions, and to make other minor updates.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
11331.1	Contractors shall be aware of the Manual updates to Pub. 100-04 Chapters 1, 22, 24, 26, and 31.	X	X	X	X					CEDI
11331.2	Contractors shall follow the new instructions added to chapter 1, section 70.8.8.6 of Pub. 100-04 when a beneficiary submits a claim on the English or Spanish Form CMS-1490S (version 01/05) on or after April 1, 2019.		X		X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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): Matt Klischer, matthew.klischer@cms.hhs.gov , Char Parks, charlene.parks@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 1 - General Billing Requirements

50.1.1 - Billing Form as Request for Payment

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

Each of the paper billing forms--CMS-1500-- Health Insurance Claim Form; and CMS-1490S-- Patient's Request for *Medical* Payment,)-- contains a patient's signature line or reference to the patient signature incorporating the patient's request for payment of benefits, authorization to release information, and assignment of benefits. When the billing form is used as the request for payment, there must be a signature, except when the provisions in §50.1.2 apply.

The Medicare Uniform Institutional Provider Bill, Form CMS-1450, does not contain a line for the patient's signature. As a result, the billing form itself cannot be used as a request for payment. Requests for payment must be obtained and retained in the provider's records. The institutional claim form contains a provider representative signature, which includes a certification that a request for payment has been obtained from the patient. See §50.1.2 for requirements for providers.

Electronic billing is required except when an exception is possible under ASCA. See §2 of this chapter for related information.

70.8.4 - Claims Forms CMS-1490S and CMS-1500

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A number of prescribed claims forms have been developed for use when requesting payment for Part B Medicare services. Many are printed and distributed nationally free of cost through CMS's Printing and Publications Branch. (See NOTE below for exception.)

In order to maintain control over the content and format of the forms, private printing of a Government form is not routinely permitted. However, if you or another organization wishes to independently print a prescribed claims form, the reproduction of a claims form must be in accordance with §422.527 of Title 20, Chapter III, Part 422 of the Code of Federal Regulations. Obtain CMS approval for printing a prescribed form. Route the written request for approval through the RO. Include the following:

- The reason or need for such reproduction;
- The intended user of the form;
- The proposed modifications or format changes, with printing or other specifications (such as realignment of data or line designations);
- The type of automatic data processing machinery, if any, for which the form is designed; and
- Estimates of printing quantity, cost per thousand, and annual usage.

NOTE: This procedure does not apply to the Form CMS-1500, Health Insurance Claim Form. A/B MACs (B), physicians and suppliers are responsible for purchasing their own forms. This form can be bought in single, multipart snap-out sets or in continuous pin-feed format. Medicare accepts any version. Forms can be obtained from local printers or printed in-house as long as it follows the CMS approved specifications developed by the National Uniform Claim Committee.

The Form CMS-l490 was formerly the basic Part B claims form. It was replaced by Form CMS-l500 for claims completed by physicians and suppliers (except ambulance suppliers), and Form CMS-l490S for claims from beneficiaries. You must, however, continue to accept and process claims received on Form CMS-1490 form after conversion to Forms CMS-l500 and CMS-l490S.

The Form CMS-1500 (Health Insurance Claim Form) is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance services), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc.

The forms described below are printed and distributed to contractors by CMS and are available in single sheets, multipart snap-out sets, or in pin-feed format.

The Form CMS-1490S (Patient's Request for *Medical* Payment) form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains *the patient's* comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Social Security Offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims. For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so. Inasmuch as the Form CMS-1490S has no provision for a diagnosis code, the diagnosis code is not required at the time of claim submission.

CMS implemented a new version of the Form CMS-1490S effective January 1, 2019. The revised form is version 01/18, OMB control number 0938-1197. The revised form will replace the previous version of the form 01/05, OMB control number 0938-0999.

The term, "Form CMS-1490S" refers to the form generically, independent of a given version.

Medicare will conduct a dual-use period (January 1, 2019 through March 31, 2019) during which Beneficiaries (or their representatives) can send Medicare claims on either the old or the revised form. When the dual-use period is over, Medicare will accept beneficiary paper claims on only the revised Form CMS-1490S, version 01/18.

The Form CMS-1556 (Prepayment Plan for Group Practices Dealing Through An A/B MAC (B)) is used by plans which, for Medicare purposes are, both Group Practice Prepayment Plans, and are paid on the basis of reasonable charges related to their costs for furnishing services to their subscribers.

70.8.8.6 – Monitoring Claims Submission Violations

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A. General

Section 1848(g)(4) of the Social Security Act requires physicians and suppliers to submit claims to Medicare carriers for services furnished on or after September 1, 1990. It also prohibits physicians and suppliers from imposing a charge for completing and submitting a claim. Payment for assigned services not filed within 1 year (for services on or after 9/1/90) are reduced 10 percent. Physicians and suppliers who fail to submit a claim or who impose a charge for completing the claim are subject to sanctions. CMS is responsible for assessing sanctions and monetary penalties for noncompliance.

Physicians and suppliers are not required to take assignment of Medicare benefits unless they are enrolled in the Medicare Participating Physician and Supplier Program or, in the case of physician services, the Medicare beneficiary is also a recipient of State medical assistance (Medicaid) or the service is otherwise subject to mandatory assignment.

B. Compliance Monitoring

To ensure that providers and suppliers are enrolled in the Medicare program and submit claims in compliance with the mandatory claims submission requirements found in §1848(g)(4) of the Social Security Act, contractors shall:

1) Process beneficiary claims submitted to A/B MACs or carriers for services that are not covered by Medicare (e.g., for hearing aids, cosmetic surgery, personal comfort services, etc.; see 42 CFR 411.15 for details), in accordance with its normal processing procedures;

2) Process beneficiary claims submitted to A/B MACs or carriers for services that are covered by Medicare and the beneficiary has submitted a complete and valid claim (Form CMS-1490S) and all supporting documentation associated with the claim, including an itemized bill with the following information:

- Date of service,
- Place of service,
- Description of illness or injury,
- Description of each surgical or medical service or supply furnished,
- Charge for each service,
- The doctor's or supplier's name and address,
- The provider or supplier's National Provider Identifier (NPI)
- *The ordering & referring provider's legal name and address and the National Provider Identifier (NPI) if known when the itemized bill is from:*
  A Clinical laboratory for ordered tests
  An independent diagnostic imaging center for ordered imaging procedures
  A supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS

If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI the contractor shall not return the claim but rather look up the provider or supplier's NPI using the NPI registry. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

3) Retain the Form-1490S and supporting documentation and manually return a copy to the beneficiary if it is for a Medicare-covered service and the claim is incomplete, does not include all required supporting documentation and/or contains invalid information. Contractors shall also include an appropriate letter that specifically communicates all the items listed above which were missing or invalid. In addition, the CMS-1490S and supporting documentation shall be maintained for purposes of the timely filing rules in the event that the beneficiary re-submits the claim.

If the Beneficiary submits a claim on the English or Spanish Form CMS-1490S (version 01/05) on or after April 1, 2019, manually return the Form CMS-1490S (version 01/05) claim to the beneficiary, and include a copy of the Form CMS-1490S (version 01/18), along with a letter instructing the beneficiary to complete and return the Form CMS-1490S (version 01/18) for processing within the time period prescribed in §70.5.

If a beneficiary submits a claim on the Form CMS-1500, manually return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5, above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

4) Retain Medicare claims records using the following disposition rules.

DISPOSITION:

1. Carriers who Microform Claims

a) Hardcopy Records - Cut off no later than the close of the calendar year (CY) in which paid. The hardcopy claim must be retained in accordance with the following:

(1) If a corresponding master microfilm has been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 3 years after the close of the CY in which paid.

(2) If a corresponding master microform record has NOT been made and verified, transfer to a Federally-approved records storage facility or hold onsite. Destroy after a total retention of 6 years and 3 months after the close of the CY in which paid.

b) Microform Records

The master microform record must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which paid.

2. Carriers Who Do Not Microfilm Claims Records

Cut off at the close of the calendar year (CY) in which paid, then transfer to a Federally-approved records storage facility. Destroy after a total retention of 6 years and 3 months. Earlier cutoff and transfer is authorized. However, the records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

a) Hardcopy Records - The hardcopy must be retained onsite until the microform has been verified. Cut off at the close of the calendar year in which paid; transfer hardcopy to a Federally-approved records storage facility only if there is a corresponding master microfilm record that can be retained for the period indicated in b. below; otherwise, the hardcopy shall be retained until the 6 years and 3 months period is reached. Earlier cutoff and transfer is authorized. However, the hardcopy must be retained for a total retention of 3 years after the close of the calendar year in which paid.

b) Microform Records - The master microform records must be retained for a total retention of 6 years and 3 months following the close of the calendar year in which payment is made.

When returning a beneficiary submitted claim, the contractor shall inform the beneficiary that the provider or supplier is required by law to submit a claim on behalf of the beneficiary (for services that would otherwise be payable), and that in order to submit the claim, the provider must enroll in the Medicare program. In addition, contractors shall encourage beneficiaries to always seek non-emergency care from a provider or supplier that is enrolled in the Medicare program.

If a beneficiary receives services from a provider or supplier that refuses to submit a claim to the A/B MAC or carrier, on the beneficiary's behalf, (for services that would otherwise be payable by Medicare), and/or refuses to enroll in the Medicare program, the beneficiary should:

(1) Notify the contractor in writing that the provider or supplier refused to submit a claim to Medicare and/or refused to enroll in Medicare, and

(2) Submit a complete Form CMS-1490S with all supporting documentation.

The contractor shall process and pay the beneficiary's claim if it is for a service that would be payable by Medicare were it not for the provider or supplier's refusal or inability to submit the claim and/or enroll in Medicare. Claims shall be adjudicated based on whether the service provided is covered or non-covered/excluded rather than on the provider's enrollment status. *If for a covered service, the claim shall be processed and the allowed amount reimbursed to the beneficiary, if appropriate. If for a non-covered/excluded service, the claim shall be processed and denied with an appropriate MSN message. For sanctioned/excluded and opt-out providers the following MSN messaging is recommended:*

Sanctioned/Excluded provider:

A sanctioned or excluded provider is an individual or business excluded from participation in the Medicare program for a stated period of time as a result of fraudulent activity, program abuse, or impermissible conduct as determined by OIG. CMS will pay the first claim submitted by a beneficiary for the services of a sanctioned/excluded physician or practitioner and immediately notify the sanctioned/excluded physician or practitioner of the exclusion. CMS will not pay a claim for sanctioned/excluded physician or practitioner services more than 15 days after the date on the notice to the physician or practitioner, or after the effective date of the exclusion, whichever is later. Under no circumstance may Medicare payment be made to any entity, including beneficiaries, for services rendered by such providers after the first claim is paid. An example of language that may be considered:

MSN Message 21.27

English
Services provided by a Medicare sanctioned/excluded provider. No Medicare payment may be made.

Spanish
Los servicios fueron brindado por un proveedor excluído de Medicare, por lo tanto Medicare no pagó por los servicios.

Opt-Out physicians and practitioners:

Medicare payment may be made for the claims submitted by a beneficiary for the services of an opt out physician or practitioner when the physician or practitioner did not privately contract with the beneficiary for services that were not emergency care services or urgent care services and that were furnished no later than 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare (see 42 C.F.R. 405.435(c)). Therefore, if the beneficiary submits a claim for a service that was furnished by an opt out physician or practitioner, then the carrier must contact the opt out physician or practitioner in order to ascertain whether the beneficiary entered into a private contract with the opt out physician or practitioner. (Note: The carrier should obtain a copy of the private contract from the opt out physician/practitioner before denying the beneficiary's claim if the beneficiary did, in fact, enter into a private contract with the physician or practitioner.) If the beneficiary did not enter into a private contract with the physician or practitioner and the beneficiary did not receive notice from the carrier that the physician opted out of Medicare, then Medicare payment may be made to the beneficiary for the non-emergency and/or non-urgent care services (assuming that the services would otherwise be payable). On the other hand, if the beneficiary did enter into a private contract with the physician or practitioner for the services or received services from the physician/practitioner 15 days after the date of a notice by the carrier that the physician or practitioner has opted out of Medicare, then no Medicare payment may be made. Medicare has instructed opt out physicians and practitioners that private contract language must include beneficiary instruction precluding the beneficiary from billing Medicare for these services. An example of language that may be considered:

MSN Message 21.26

English
Claim denied because services were provided by an Opt-Out physician or practitioner. No Medicare payment may be made.

Spanish
La reclamación fue denegada porque los servicios fueron brindados por un médico ó proveedor que decidió no participar en Medicare, por lo tanto, Medicare no pagó por los servicios.

Contractors shall maintain documentation of beneficiary complaints involving violations of the mandatory claims submission policy and a list of the top 50 violators, by State, of the mandatory claim submission policy.

Contractors are encouraged to educate providers and suppliers that they must be enrolled in the Medicare program before they submit claims for services furnished or supplied to any Medicare beneficiary.

The above policy, including the NPI requirement, is not applicable for foreign beneficiary claims submitted for covered services. These claims should be processed using guidelines for foreign claims.

The above policy, including the NPI requirement, is not applicable to beneficiary claims submitted to DMEMACs for durable medical equipment, prosthetics, orthotics, and supplies. These claims should be processed by DMEMACs using current procedures.

C. Exception When Physician, Other Practitioner, or Supplier Is Excluded From Participating in Medicare Program

Section 1848(g)(4) of the Social Security Act requires physicians, other practitioners, or suppliers to submit claims to Medicare carriers for services furnished after September 1, 1990. This **does not** apply to physicians, other practitioners, or suppliers who have been excluded from participating in the Medicare program. Physicians, other practitioners, and suppliers who have been excluded from the Medicare program are prohibited from submitting claims or causing claims to be submitted. See the Medicare Program Integrity Manual for procedures concerning claims submitted by an excluded practitioner, his/her employer, or a beneficiary for services or items provided by an excluded physician, other practitioner, or supplier. Carriers must maintain the systems capability to identify claims submitted by excluded physicians, other practitioners, or suppliers as well as items or services provided, ordered, prescribed, or referred by an excluded party.

When an excluded physician, other practitioner, or supplier has not submitted a claim on behalf of the beneficiary and/or the beneficiary has submitted the claim themselves, do **not** send a notification letter to the physician, other practitioner, or supplier warning of civil monetary penalties due to noncompliance with §1848(g)(4)(A) of the Act. Instead, follow the instructions in the Program Integrity Manual.

80.3.2 - Handling Incomplete or Invalid Claims

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

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.

Claims processing specifications describe whether a data element is required, not required, or conditional (a data element which is required when certain conditions exist). The status of these data elements will affect whether or not an incomplete or invalid claim (hardcopy or electronic) will be "returned as unprocessable" by the A/B MAC (B) or "returned to provider" (RTP) by the A/B MAC (A). The contractor shall not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

If a data element is required and it is not accurately entered in the appropriate field, the contractor returns the claim to the provider of service.

- If a data element is required, or is conditional (a data element that is required when certain conditions exist) and the conditions of use apply) and is missing or not accurately entered in its appropriate field, the contractor shall return as unprocessable or RTP the claim to either the supplier or provider of service.

NOTE: Effective for claims with dates of service (DOS) on or after the implementation date of the ordering and referring phase 2 edits, Part B clinical lab and imaging technical or global component claims, Durable Medical Equipment, Prosthetics, claims and Home Health Agency (HHA) claims shall be denied, in accordance with CMS-6010-F final rule published on April 24, 2012, if the ordering or referring provider's information is invalid or if the provider is not of a specialty that is eligible to order and refer.

- If a claim must be returned as unprocessable or RTP for incomplete or invalid information, the contractor shall, at minimum, notify the provider of service of the following information:
    - Beneficiary's Name;
    - Medicare beneficiary identifier;
    - Dates of Service (MMDDCCYY) (Eight-digit date format effective as of October 1, 1998);
    - Patient Account or Control Number (only if submitted);
    - Medical Record Number (FIs only, if submitted); and
    - Explanation of Errors (e.g., Remittance Advice Reason and Remark Codes)

NOTE: Some of the information listed above may in fact be the information missing from the claim. If this occurs, the contractor includes what is available.

Depending upon the means of return of a claim, the supplier or provider of service has various options for correcting claims returned as unprocessable or RTP for incomplete or invalid information. They may submit corrections either in writing, on-line, or via telephone when the claim was suspended for development, or submit as a "corrected" claim or as an entirely new claim if data from the original claim was not retained in the system, as with a front-end return, or if a remittance advice was used to return the claim. The chosen mode of submission, however, must be currently supported and appropriate with the action taken on the claim.

NOTE: The supplier or provider of service must not be denied any services (e.g., modes of submission or customer service), other than a review, to which they would ordinarily have access.

- If a claim or a portion of a claim is "returned as unprocessable" or RTP for incomplete or invalid information, the contractor does not generate an MSN to the beneficiary.
- The notice to the provider or supplier will not contain the usual reconsideration notice, but will show each applicable error code or equivalent message.
- If the contractor uses an electronic or paper remittance advice notice to return an unprocessable claim, or a portion of unprocessable claim:

1. The remittance advice must demonstrate all applicable error codes. At a minimum there must be a CARC/RARC combination that is compliant with CAQH CORE Business Scenario Two.

2. The returned claim or portion must be stored and annotated, as such, in history, if applicable. If contractors choose to suspend and develop claims, a mechanism must be in place where the contractor can re-activate the claim or portion for final adjudication.

A. Special Considerations

- If a "suspense" system is used for incomplete or invalid claims, the contractor will not deny the claim with appeal rights if corrections are not received within the suspense period, or if corrections

are inaccurate. The contractor must return the unprocessable claim, without offering appeal rights, to the provider of service or supplier.

For assigned and unassigned claims submitted by beneficiaries (Form CMS-1490S), that are incomplete or contain invalid information, contractors shall manually return the claims to the beneficiaries. If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI, and the contractor can determine the NPI using the NPI registry, the contractor shall continue to process and adjudicate the claim. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

Contractors shall send a letter to the beneficiary with information explaining which information is missing, incorrect or invalid; information explaining the mandatory claims filing requirements; instructions for resubmitting the claim if the provider or supplier refuses to file the claim, or enroll in Medicare, and shall include language encouraging the beneficiary to seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. Contractors shall also notify the provider or supplier about his/her obligation to submit claims on behalf of Medicare beneficiaries and that providers and suppliers are required to enroll in the Medicare program to receive reimbursement.

Contractors shall consider a complete claim to have all items on the Form CMS-1490S completed along with an itemized bill with the following information: date of service, place of service, description of each surgical or medical service or supply furnished; charge for each service; treating doctor's or supplier's name and address; diagnosis code; procedure code and the provider or supplier's NPI. *The ordering & referring provider's legal name and address and the National Provider Identifier (NPI) if known must be included on the itemized bill if from a Clinical laboratory for ordered tests; an independent diagnostic imaging center for ordered imaging procedures or a supplier of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for ordered DMEPOS.* Required information on a claim must be valid for the claim to be considered as complete.

If a beneficiary submits a claim on the Form CMS-1500, return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5 above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

NOTE: Telephone inquiries are encouraged.

- Contractors shall not return an unprocessable claim if the appropriate information for both "required" and "conditional" data element requirements other than an NPI when the NPI is effective is missing or inaccurate but can be supplied through internal files. Contractors shall not search their internal files to correct missing or inaccurate "required" and "conditional" data elements required under Sections 80.3.2.1.1 through 80.3.2.1.3 and required for HIPAA compliance for claims governed by HIPAA.

- For either a paper or electronic claim, if all "required" and "conditional" claim level information that applies is complete and entered accurately, but there are both "clean" and "dirty" service line items, then split the claim and process the "clean" service line item(s) to payment and return as unprocessable the "dirty" service line item(s) to the provider of service or supplier**. NOTE:** This requirement applies to carriers only.

No workload count will be granted for the "dirty" service line portion of the claim returned as unprocessable. The "clean" service line portion of the claim may be counted as workload **only if it is processed through the remittance process**. Contractors must abide by the specifications written in the above instruction; return the "dirty" service line portion without offering appeal rights.

- Workload will be counted for claims returned as unprocessable through the remittance process. Under no circumstances should claims returned as unprocessable by means other than the remittance process (e.g., claims returned in the front-end) be reported in the workload reports submitted to CMS. The contractor is also prohibited from moving or changing the action on an edit that will result in an unprocessable claim being returned through the remittance process. If the current action on an edit is to suspend and develop, reject in the front or back-end, or return in the mailroom, the contractor must continue to do so. Workload is only being granted to accommodate those who have edits which currently result in a denial. As a result, workload reports should not deviate significantly from those reports prior to this instruction.

NOTE: Rejected claims are not counted as an appeal on resubmissions.

B. Special Reporting of Unprocessable Claims Rejected through the Remittance Process (Carriers Only):

A/B MACs (B) must report "claims returned as unprocessable on a remittance advice" on line 15 (Total Claims Processed) and on line 14 (subcategory Non-CWF Claims Denied) of page one of your Form CMS-1565. Although these claims are technically not denials, line 14 is the only suitable place to report them given the other alternatives. In addition, these claims should be reported as processed "not paid other" claims on the appropriate pages (pages 2-9) of CROWD Form T for the reporting month in which the claims were returned as unprocessable through the remittance process. Also, A/B MACs (B) report such claims on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) system. They report the "number of such claims returned during the month as unprocessable through the remittance process" under Column 1 of Form Y on a line using code "0003" as the identifier.

If a supplier, physician, or other practitioner chooses to provide missing or invalid information for a suspended claim by means of a telephone call or in writing (instead of submitting a new or corrected claim), A/B MACs (B) do not report this activity as a claim processed on Form CMS-1565/1566. Instead, they subtract one claim count from line 3 of Form Y for the month in which this activity occurred.

EXAMPLE: Assume in the month of October 2001 the carrier returned to providers 100 claims as unprocessable on remittance advices. The carrier should have included these 100 claims in lines 14 and 15 of page 1 of your October 2001 Form CMS-1565. During this same month, assume the carrier received new or corrected claims for 80 of the 100 claims returned during the month. These 80 claims should have been counted as claims received in line 4 of your October 2001 Form CMS-1565 page one (and subsequently as processed claims for the reporting month when final determination was made).

Also, during October 2001, in lieu of a corrected claim from providers, assume the carrier received missing information by means of a telephone call or in writing for 5 out of the 100 claims returned during October 2001. This activity should not have been reported as new claims received (or subsequently as claims processed when adjustments are made) on Form CMS-1565. On line 3 of Form Y for October 2001, the A/B MAC (B) should have reported the number 95 (From claims returned as unprocessable through the remittance process minus 5 claims for which the carrier received missing or invalid information by means of a telephone call or in writing.

For the remaining 15 claims returned during October 2001 with no response from providers in that same month, the carrier should have reported on the Form CMS-1565 or Form Y, as appropriate, any subsequent activity in the reporting month that it occurred. For any of these returned claims submitted as new or corrected claims, the A/B MAC (B) should have reported their number as receipts on line 4 of page one of Form CMS-1565. For any of these returned claims where the supplier or provider of service chose to supply missing or invalid information by means of a telephone call or in writing, the A/B MAC (B) should not have counted them again on Form CMS-1565, but subtracted them from the count of returned claims reported on line 3 of Form Y for the month this activity occurred.

C. Exceptions (A/B MACs (B) Only)

The following lists some exceptions when a claim may not be “returned as unprocessable” for incomplete or invalid information.

A/B MACs (B) shall not return a claim as unprocessable:

If a patient, individual, physician, supplier, or authorized person’s signature is missing, but the signature is on file, or if the applicable signature requirements have been met, do not return a claim as unprocessable where an authorization is attached to the claim or if the signature field has any of the following statements (unless an appropriate validity edit fails):

Acceptable Statements for Form CMS-1500:

- For items 12, 13, and 31, “Signature on File” statement and/or a computer generated signature;
- For items 12 and 13, Beneficiary’s Name “By” Representative’s Signature;

For item 12, “X” with a witnessed name and address. (Chapter 26 for instructions.)

D. Misdirected Claims

See §10.1.9 for instructions on handling claims that are submitted to the wrong contractor, or to the wrong payment jurisdiction.

Medicare Claims Processing Manual
Chapter 22 - Remittance Advice

40.1 - ASC X12 835

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

The ASC X12 835 is a variable-length record designed for wire transmission and is not suitable for use in application programs. Therefore, shared systems generate a flat file version of the ASC X12 835. MACs must translate that flat file into the variable length ASC X12 835 record for transmission to providers or their billing services or clearinghouse. See Chapter 24 for technical information about transmission of the ASC X12 835. The updated flat files are posted at:

https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html

Go to "Downloads", and click on the file you want.

The MAC requirements are:

- Send the remittance data directly to providers or their designated billing services or clearinghouses;
- Provide sufficient security to protect beneficiaries' privacy. The MAC does not allow any party to view beneficiary information, unless authorized by specific instructions from CMS
- Issue the remittance advice specifications and technical interface specifications to all requesting providers within *three* weeks of their request. Interface specifications must contain sufficient detail to enable a reasonably knowledgeable provider to interpret the RA, without the need to pay the MAC or an associated business under the same corporate umbrella for supplemental services or software;
- A/B MACs (A) allow Part A providers to receive a Standard Paper Remittance Advice (SPR) in addition to the ASC X12 835 during the first 31 days of receiving ERAs and during other testing. After that time, A/B MACs (A) do not send a hard copy version of the ASC X12 835, in addition to the electronic transmission, in production mode. They should contact CMS if this requirement causes undue hardship for a particular provider, and a waiver is needed;
- A/B MACs and DME MACs must suppress the distribution of SPRs to those Part B providers//suppliers (or a billing agent, clearinghouse, or other entity receiving ERAs on behalf of those providers/suppliers) after 45 days of receiving both SPR and ERA formats. In rare situations (e.g., natural or man-made disasters) exceptions to this policy may be allowed at the discretion of CMS. A/B MACs and DME MACs should contact CMS if a waiver is needed;
- MACs may release an ERA prior to the payment date, but never later than the payment date;
- Ensure that their provider file accommodates the data necessary to affect EFT, either through use of the ACH or the ASC X12 835 format;
- Pay the costs of transmitting EFT through their bank to the ACH. Payees are responsible for the telecommunications costs of EFT from the ACH to their bank, as well as the costs of receiving ASC X12 835 data once in production mode; and
- Provide for sufficient back-up to allow for retransmission of garbled or misdirected transmissions.

Every ASC X12 835 transaction issued by A/B MACs and DME MACs must comply with the implementation guide (IG) requirements; i.e., each required segment, and each situational segment when the situation applies, must be reported. Required or applicable situational data element in a required or situational segment must be reported, and the data in a data element must meet the minimum length and data attribute (AN, ID, R, etc.) specifications in the implementation guide.

Back end validation must be performed to ensure that these conditions are met. A/B MACs and DME MACs are not required to validate codes maintained by their shared systems, such as Healthcare Common Procedure Coding System (HCPCS), that are issued in their shared system's flat file for use in the body of an ASC X12 835, but they are required to validate data in the ASC X12 835 envelope as well as the codes that they maintain, such as claim adjustment reason codes and remittance advice remark codes, that are reported in the ASC X12 835. MACs do not need to re-edit codes or other data validated during the claim adjudication process during this back end validation. Valid codes are to be used in the flat file, unless:

- A service is being denied or rejected using an ASC X12 835 for submission of an invalid code, in which case the invalid code must be reported on the ASC X12 835;
- A code was valid when received, but was discontinued by the time the ASC X12 835 is issued, in which case, the received code must be reported on the ASC X12 835; or
- A code is received on a paper claim, and does not meet the required data attribute(s) for the HIPAA compliant ASC X12 835, in which case, "gap filling" would be needed if it were to be inserted in a compliant ASC X12 835.

Additionally A/B MACs and Common Electronic Data Interchange (CEDI) for DME MACs must follow the CMS instructions for Receipt, Control and Balancing.

50.1 - The Do Not Forward (DNF) Initiative

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

As part of the Medicare DNF Initiative, A/B MACs and DME MACs must use "return service requested" envelopes for mailing all hardcopy remittance advices. When the post office returns a remittance advice due to an incorrect address, follow the same procedures followed for returned checks; that is:

- Flag the provider "DNF"; A/B MAC staff must notify the provider enrollment area, and DME MACs must notify the National Supplier Clearing House (NSC);
- Cease generating any further payments or remittance advice to that provider or supplier until they furnish a new address that is verified; and
- When the provider returns a new address, MACs remove the DNF flag after the address has been verified, and pay the provider any funds still being held due to a DNF flag. MACs must also reissue any remittance that has been held as well.

NOTE: Previously, CMS required corrections only to the "pay to" address. However, with the implementation of this new initiative, CMS requires corrections to all addresses before the MAC can remove the DNF flag and begin paying the provider or supplier again. Therefore, do not release any payments to DNF providers until the provider enrollment area or the National Supplier Clearinghouse (NSC) has verified and updated all addresses for that provider's location. MACs must initially publish the requirement that providers must notify the A/B MAC or NSC of any changes of address, both on their Web sites and in their next regularly scheduled bulletins. MACs must continue to remind suppliers and providers of this requirement in their bulletins at least yearly thereafter. See Chapter 1 for additional information pertaining to the DNF initiative.

60.2 – Claim Adjustment Reason Codes

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

Claim Adjustment Reason Codes (CARCs) are used on the Medicare electronic and paper remittance advice, and Coordination of Benefit (COB) claim transaction. The Claim Adjustment Status and Reason Code Maintenance Committee maintains this code set. A new code may not be added, and the indicated wording may not be modified without the approval of this committee. These codes were developed for use by all

U.S. health payers. As a result, they are generic, and there are a number of codes that do not apply to Medicare. This code set is updated three times a year. MACs shall use only most current valid codes in ERA, SPR, and COB claim transactions.

Any reference to procedures or services mentioned in the reason codes apply equally to products, drugs, supplies or equipment. References to prescriptions also include certificates of medical necessity (CMNs).

These reason codes explain the reasons for any financial adjustments, such as denials, reductions or increases in payment. These codes may be used at the service or claim level, as appropriate. Current ASC X12 835 structures only allow one reason code to explain any one specific adjustment amount.

There are basic criteria that the Claim Adjustment Status and Reason Code Maintenance Committee considers when evaluating requests for new claim adjustment reason codes:

- Can the information be conveyed by the use or modification of an existing reason code?
- Is the information available elsewhere in the ASC X12 835?
- Will the addition of the new reason code make any significant difference in the action taken by the provider who receives the message?

The list of Claim Adjustment Reason Codes can be found at:
http://www.wpc-edi.com/codes

The updated list is published three times a year after the committee meets before the ASC X12 trimester meeting in the months of January/February, *May/*June, and September/October. MACs must make sure that they are using the latest approved claim adjustment reason codes in ERA, SPR and COB transaction by implementing necessary code changes as instructed in the Recurring Code Update Change Requests (CRs) or any other CMS instruction and/or downloading the list from the WPC website after each update. The Shared System Maintainers shall make sure that a deactivated code (either reason or remark) is not allowed to be used in any original business message, but is allowed and processed when reported in derivative business messages. Code deactivation may be implemented prior to the stop date posted at the WPC web site to follow Medicare release schedule. SSMs shall implement deactivation on the earlier date if the implementation date in the recurring code update CR is different than the stop date posted at the WPC Web site.

The MACs are responsible for entering claim adjustment reason code updates to their shared system and entry of parameters for shared system use to determine how and when particular codes are to be reported in remittance advice and coordination of benefits transactions. In most cases, reason and remark codes reported in remittance advice transactions are mapped to alternate codes used by a shared system. These shared system codes may exceed the number of the reason and remark codes approved for reporting in a remittance advice transaction. A particular ASC X12 835 reason or remark code might be mapped to one or more shared system codes, or vice versa, making it difficult for a MAC to determine each of the internal codes that may be impacted by remark or reason code modification, retirement, or addition.

Shared systems must provide a crosswalk between the reason and remark codes to the shared system internal codes so that a MAC can easily locate and update each internal code that may be impacted by a remittance advice reason/remark code change to eliminate the need for lengthy and error prone manual MAC searches to identify each affected internal code. Shared systems must also make sure that 5-position remark codes can be accommodated at both the claim and service level for ASC X12 835 version 4010 onwards.

The effective date of programming for use of new or modified reason/remark codes applicable to Medicare is the earlier of the date specified in the CMS manual transmittal or CMS Recurring Code Update change request or the Medicare Claims Processing Manual transmittal that implemented a policy change that led to the issuance of the new or modified code. MACs must notify providers of the new and/or modified codes

and their meanings in a provider bulletin or other instructional release prior to issuance of remittance advice transactions that include these changes. Some CARCs are so generic that the reason for adjustment cannot be communicated clearly without at least one remark code. These CARCs have a note added to the text for identification. A/B MACs and DME MACs must use at least one appropriate remark code when using one of these CARCs.

Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims

30.1 - EDI Enrollment

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A/B MACs and CEDI are required to furnish new providers that request Medicare claim privileges information on EDI. A/B MACs and CEDI are required to assess the capability of entities to submit data electronically, establish their qualifications (see test requirements in §50), and enroll and assign submitter EDI identification numbers to those approved to use EDI. All providers are required to submit their claims electronically, per ASCA, unless they qualify for a waiver (see section 90 below).

The EDI enrollment process for the Medicare beneficiary inquiry system *HETS (HIPAA Eligibility Transaction System (HETS 270/271))* is currently a separate process. Information on the EDI enrollment process for HETS can be found on the CMS HETSHelp website (http://www.cms.gov/HETSHelp/).

A provider must obtain an NPI and furnish that NPI to their A/B MAC and CEDI prior to completion of an initial EDI Enrollment Agreement and issuance of an initial EDI number and password by that contractor. The A/B MACs and CEDI are required to verify that NPI is *active in the Provider Enrollment, Chain and Ownership System (PECOS). If the A/B MAC or CEDI is not able to verify the NPI as active in PECOS*, the EDI Enrollment Agreement is denied and the provider is encouraged to contact the A/B MAC provider enrollment department (for Medicare Part A and Part B providers) or the National Supplier Clearinghouse (for DME suppliers) to resolve the issue. Once the NPI is properly verified, the provider can reapply the EDI Enrollment Agreement.

A provider's EDI number and password serve as a provider's electronic signature and the provider would be liable if any entity with which the provider improperly shared the ID and password performed an illegal action while using that ID and password. A provider's EDI access number and password are not part of the capital property of the provider's operation, and may not be given to a new owner of the provider's operation. A new owner must obtain their own EDI access number and password. When leaving the Medicare Program, a provider must notify their MAC to deactivate the EDI number.

If providers elect to submit/receive transactions electronically using a third party such as a billing agent **or** a clearinghouse, the A/B MACs or CEDI must notify those providers that they are required to have an agreement signed by that third party. The third party must agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. (These agreements are not to be submitted to Medicare, but are to be retained by the providers.) The providers must also be informed that they are not permitted to share their personal EDI access number and password with any billing agent **or** clearinghouse~~.~~ Providers must also not share their personal EDI access number to anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim. No other non-staff individuals or entities may be permitted to use a provider's EDI number and password to access Medicare systems. Clearinghouse and other third party representatives must obtain and use their own unique EDI access number and password from those A/B MACs or CEDI to whom they will send or receive EDI transactions. For a complete reference to security requirements see section 40.1.2.2 below and refer to the Appendix A CMSR High Impact Level Data document (sections IA-2 and SA-9) located on the CMS website *https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/CIO-Directives-and-Policies/CIO-IT-Policy-Library-Items/STANDARD-ARS-Acceptable-Risk-Safeguards.html*.

50.3.4 - Common Edits and Enhancement Module (CEM) Code Sets Requirements

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

The functionality of the CEM is dependent on the standard system maintainers (SSM) providing current code sets for inbound claims and claim status inquiries to be edited against. This requires the CEM maintainer to update the following code sets on a quarterly release basis in order to align with industry:

- Country Codes (ISO 3166-1)
- Country Subdivision Codes (ISO 3166-2)
- State Codes (United States, Canada, Mexico)
- Not Otherwise Classified (NOC) Procedure Codes (as defined by CMS)
- National Uniform Billing Committee (NUBC) Condition Codes (that are valid for use on the 837 Professional claim per the National Uniform Claim Committee (NUCC))
- Ambulance Modifiers
- Health Insurance Prospective Payment System (HIPPS) (as updated and maintained by CMS)

A/B MACs are required to validate the incoming codes listed above against the most recent codes sets provided by the SSM. CMS will notify the shared system maintainers (via Recurring Update Notification) to load the most recent code sets into the CEM environment for download to the A/B MAC local data center (LDC) in conjunction with the quarterly release.

The CEM maintainer also updates the following code sets on a frequency basis other than quarterly in order to align with industry:

- ZIP codes
- Claim Adjustment Reason Codes (CARC)
- Anesthesia Modifiers
- Diagnosis Related Groups (DRG) codes
- Healthcare Common Procedure Coding System (HCPCS) codes
- Health Insurance Premium Payment System (HIPPS) codes
- International Classification of Diseases, (ICD) codes
- National Drug Codes (NDC) (as published by the Federal Drug Administration(FDA))
- National Provider Identifier (NPI)
- Remittance Advice Remark Codes (RARC)
- Taxonomy Codes
- Procedure Code Modifier Codes
- Admission Source Codes
- Admission Type Codes
- Patient Status Codes
- Condition Codes
- Occurrence Codes
- Occurrence Span Codes
- Value Codes
- Revenue Codes
- Uniform Bill Type codes
- Provider Control File (PCF) - Part B only

A/B MACs are required to validate the incoming codes listed above against the most recent codes sets provided by the SSM. When the above listed reference code sets are updated, they are sent to the A/B MAC (LDC) as part of nightly code updates.

90.1 - Small Providers and Full-Time Equivalent Employee Self-Assessments

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

A “small provider” is defined at 42 CFR section 424.32(d)(1)(vii) to mean A) a provider of services (as that term is defined in section 1861(u) of the Social Security Act) with fewer than 25 full-time equivalent (FTE) employees; or B) a physician, practitioner, facility or supplier that is not otherwise a provider under section 1861(u) with fewer than 10 FTEs. To simplify implementation, Medicare considers all providers that have fewer than 25 FTEs and that are required to bill a Medicare A/B MAC (A)to be small; and considers all

physicians, practitioners, facilities, or suppliers with fewer than 10 FTEs and that are required to bill a A/B MAC (B) or DME MAC to be small.

The ASCA law and regulation do not modify pre-existing laws or employer policies defining full time employment. Each employer has an established policy, subject to certain non-Medicare State and Federal regulations, that define the number of hours employees must work on average on a weekly, biweekly, monthly, or other basis to qualify for full-time benefits. Some employers do not grant full-time benefits until an employee works an average of 40 hours a week, whereas another employer might consider an employee who works an average of 32 hours a week to be eligible for full-time benefits. An employee who works an average of 40 hours a week would always be considered full time, but employees who work a lesser number of hours weekly on average could also be considered full time according to the policy of a specific employer.

Everyone on staff for whom a health care provider withholds taxes and files reports with the Internal (Revenue Service (IRS) using an Employer Identification Number (EIN) is considered an employee, including if applicable, a physician(s) who owns a practice and provides hands on services and those support staff who do not furnish health care services but do retain records of, perform billing for, order supplies related to, provide personnel services for, and otherwise perform support services to enable the provider to function. Unpaid volunteers are not employees. Individuals who perform services for a provider under contract, such as individuals employed by a billing agency or medical placement service, for whom a provider does not withhold taxes, are not considered members of a provider's staff for FTE calculation purposes when determining whether a provider can be considered as "small" for electronic billing waiver purposes.

Medical staff sometimes work part time, or may work full time but their time is split among multiple providers. Part time employee hours must also be counted when determining the number of FTEs employed by a provider. For example, if a provider has a policy that anyone who works at least 35 hours per week on average qualifies for full-time benefits, and has 5 full-time employees and 7 part-time employees, each of whom works 25 hours a week, that provider would have 10 FTEs (5+[7 x 25= 175 divided by 35= 5]).

In some cases, the EIN of a parent company may be used to file employee tax reports for multiple providers under multiple provider numbers. In that instance, it is acceptable to consider only those staff, or staff hours worked for a particular provider *(National Provider Identifier (NPI))* to calculate the number of FTEs employed by that provider. For example, ABC Health Care Company owns hospital, home health agency (HHA), ambulatory surgical center (ASC), and durable medical equipment (DME) subsidiaries. Some of those providers may bill A/B MACs or DME MACs. All have separate provider numbers but the tax records for all employees are reported under the same EIN to the IRS. There is a company policy that staff must work an average of 40 hours a week to qualify for full time benefits.

Some of the same staff split hours between the hospital and the ASC, or between the DME and HHA subsidiaries. To determine total FTEs by provider number, it is acceptable to base the calculation on the number of hours each staff member contributes to the support of each separate provider by provider number. First, each provider would need to determine the number of staff who work on a full-time basis under a single provider number only; do not count more than 40 hours a week for these employees. Then each provider would need to determine the number of part-time hours a week worked on average by all staff who furnished services for the provider on a less than full- time basis. Divide that total by 40 hours to determine their full-time equivalent total. If certain staff members regularly work an average of 60 hours per week, but their time is divided 50 hours to the hospital and 10 hours to the ASC, for FTE calculation purposes, it is acceptable to consider the person as 1 FTE for the hospital and .25 FTE for the ASC.

In some cases, a single provider number and EIN may be assigned, but the entity's primary mission is not as a health care provider. For instance, a grocery store's primary role is the retail sale of groceries and ancillary items including over the counter medications, but the grocery store has a small pharmacy section that provides prescription drugs and some DME to Medicare beneficiaries. A large drug store has a pharmacy department that supplies prescriptions and DME to Medicare beneficiaries but most of the store's

revenue and most of their employees are not involved with prescription drugs or DME and concentrate on non-related departments of the store, such as film development, cosmetics, electronics, cleaning supplies, etc. A county government uses the same EIN for all county employees but their health care provider services are limited to furnishing of emergency medical care and ambulance transport to residents. For FTE calculation purposes, it is acceptable to include only those staff members of the grocery store, drug store, or county involved with or that support the provision of health care in the FTE count when assessing whether a small provider waiver may apply.

Support staff who should be included in the FTE calculation in these instances include but are not necessarily limited to those that restock the pharmacy or ambulance, order supplies, maintain patient records, or provide billing and personnel services for the pharmacy or emergency medical services department if under the same EIN, according to the number of hours on average that each staff member contributes to the department that furnishes the services or supplies for which the Medicare provider number was issued.

Providers that qualify as “small” automatically qualify for waiver of the requirement that their claims be submitted to Medicare electronically. Those providers are encouraged to submit their claims to Medicare electronically, but are not required to do so under the law. Small providers may elect to submit some of their claims to Medicare electronically, but not others. Submission of some claims electronically does not negate their small provider status nor obligate them to submit all of their claims electronically.

In the event that a provider uses a clearinghouse or a billing agent to submit claims, it is the number of FTEs on the provider’s staff, not those on the staff of the billing agent or the clearinghouse, that determine whether the provider may be considered small for Medicare paper claim submission purposes.

Medicare Claims Processing Manual
Chapter 26 - Completing and Processing Form CMS-1500 Data Set

Table of Contents
(Rev. 4388, Issued: 09-06-19)

Transmittals for Chapter 26

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

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

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.

Additional information for form version 02/12: Although this version of the form includes space for a qualifier, Medicare does not use this information; do not enter a qualifier in item 14.

Item 15 - Leave blank.

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. Similarly, if Medicare policy requires you to report a supervising physician, enter this information in item 17. When a claim involves multiple referring, ordering, or supervising physicians, use a separate CMS-1500 claim form for each ordering, referring, or supervising physician.

Additional instructions for form version 02/12: Enter one of the following qualifiers as appropriate to identify the role that this physician (or non-physician practitioner) is performing:

Qualifier	Provider Role
DN	Referring Provider
DK	Ordering Provider
DQ	Supervising Provider

Enter the qualifier to the left of the dotted vertical line on item 17.

NOTE: Under certain circumstances, Medicare permits a non-physician practitioner to perform these roles. Refer to Pub 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Enter non-physician practitioner information according to the rules above for physicians.

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.

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. 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;

- Effective for claims with dates of service on or after October 1, 2012, all claims for physical therapy, occupational therapy, or speech-language pathology services, including those furnished incident to a physician or nonphysician practitioner, require that the name and NPI of the certifying physician or nonphysician practitioner of the therapy plan of care be entered as the referring physician in Items 17 and 17b.

Item 17a - Leave blank.

Item 17b - Enter the NPI of the referring, ordering, or supervising physician or non-physician practitioner listed in item 17. All physicians and non-physician practitioners 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 NPI of his/her attending physician when a physician providing routine foot care submits claims.

NOTE: Effective May 23, 2008, all provider identifiers submitted on the CMS-1500 claim form 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 A/B MAC (B) review.

Instructions for Not Otherwise Classified (NOC) Codes – Any unlisted services or procedure code. **Note:** When reporting NOC codes, this field must be populated as specified below.

Enter the drug's name and dosage when submitting a claim for 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 shall be submitted with the claim.

When billing for unlisted laboratory tests using a NOC code, this field **MUST** include the specific name of the laboratory test(s) and/or a short descriptor of the test(s). Claims for unlisted laboratory tests that are received without this information shall be treated according to the requirements found in Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, Section 80.3.2 and “returned as unprocessable.” Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA) requires reporting entities to report private payor payment rates for laboratory tests and the corresponding volumes of tests. In compliance with PAMA, CMS must collect private payor data on unique tests currently being paid as a NOC code, Not Otherwise Specified (NOS) code, or unlisted service or procedure code.

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," 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 demonstration ID number "56" for all national Laboratory Affordable Care Act Section 113 Demonstration Claims.

Enter the NPI of the physician who is performing the technical or professional component of a diagnostic test that is subject to the anti-markup payment limitation. (See Pub. 100-04, chapter 1, section 30.2.9 for additional information.)

NOTE: Effective May 23, 2008, all provider identifiers submitted on the CMS-1500 claim form 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 A/B MACs (B) 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 the anti-markup payment limitation. Enter the acquisition 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 anti-markup tests are included on the claim." When "yes" is annotated, item 32 shall be completed. When billing for multiple anti-markup tests, each test shall be submitted on a separate claim form CMS-1500. Multiple anti-markup 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 the anti-markup payment limitation.

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 diagnosis codes to the highest level of specificity for the date of service. Enter the diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Reminder: Do not report ICD-10-CM codes for claims with dates of service prior to implementation of ICD-10-CM, on either the old or revised version of the CMS-1500 claim form.

For form version 08/05, report a valid ICD-9-CM code. Enter up to four diagnosis codes.

For form version 02/12, it may be appropriate to report either ICD-9-CM or ICD-10-CM codes depending upon the dates of service (i.e., according to the effective dates of the given code set).

- The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable ICD indicator according to the following:

Indicator	Code Set
9	ICD-9-CM diagnosis
0	ICD-10-CM diagnosis

  Enter the indicator as a single digit between the vertical, dotted lines.

- Do not report both ICD-9-CM and ICD-10-CM codes on the same claim form. If there are services you wish to report that occurred on dates when ICD-9-CM codes were in effect, and others that occurred on dates when ICD-10-CM codes were in effect, then send separate claims such that you report only ICD-9-CM or only ICD-10-CM codes on the claim. (See special considerations for spans of dates below.)

- If you are submitting a claim with a span of dates for a service, use the "from" date to determine which ICD code set to use.

- Enter up to 12 diagnosis codes. Note that this information appears opposite lines with letters A-L. Relate lines A- L to the lines of service in 24E by the letter of the line. Use the highest level of specificity. Do not provide narrative description in this field.

- Do not insert a period in the ICD-9-CM or ICD-10-CM code.

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 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.

For ambulance claims, enter the ZIP code of the loaded ambulance trip's point-of-pickup.

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

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate 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 setting, 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 patient who is a registered inpatient or an outpatient (off campus or on campus) of a hospital, use the inpatient hospital POS code 21, Off Campus-Outpatient Hospital POS code 19, or On Campus-Outpatient Hospital POS code 22, respectively, as discussed in section 10.5 of this chapter.

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 CMS-1500 claim form has the capacity 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 a NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

Item 24E - This is a required field. Enter the diagnosis code reference number or letter (as appropriate, per form version) as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. Enter only one reference number/letter per line item. When multiple services are performed, enter the primary reference number/letter for each service.

When using form version 08/05, this reference will be either a 1, or a 2, or a 3, or a 4.

When using form version 02/12, the reference to supply in 24E will be a letter from A-L. Otherwise, the instructions above apply.

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.

Beginning with dates of service on and after January 1, 2011, for ambulance mileage, enter the number of loaded miles traveled rounded up to the nearest tenth of a mile up to 100 miles. For mileage totaling 100 miles and greater, enter the number of covered miles rounded up to the nearest whole number miles. If the total mileage is less than 1 whole mile, enter a “0” before the decimal (e.g. 0.9). See Pub. 100-04, chapter 15, §20.2 for more information on loaded mileage and §30.1.2 for more information on reporting fractional mileage.

NOTE: This field should contain an appropriate numerical value. The A/B MAC (B) should program their system to automatically default "1" unit when the information in this field is missing to avoid returning as unprocessable, except on claims for ambulance mileage. For ambulance mileage claims, contractors shall automatically default “0.1” unit when total mileage units are missing in this field.

Item 24H - Leave blank. Not required by Medicare.

Item 24I - *Leave Blank. Not required by Medicare.*

Item 24J - 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.

This unprocessable instruction does not apply to influenza virus and pneumococcal vaccine claims submitted on roster bills as they do not require a rendering provider NPI.

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 - For services payable under the physician fee schedule and anesthesia services, 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, only one name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted. Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for anti-markup tests. When more than one supplier is used, a separate CMS-1500 claim form shall be used to bill for each supplier. (See Pub. 100-04, chapter 1, §10.1.1.2 for more information on payment jurisdiction for claims subject to the anti-markup limitation.)

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 A/B MAC (B) 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 (DME MAC only). This field is required. When more than one supplier is used, a separate CMS-1500 claim form 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 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.

Effective for claims submitted with a receipt date on and after October 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier on the claim on reference laboratory claims, even if the performing physician or supplier is enrolled in a different A/B MAC (B) jurisdiction. See Pub. 100-04, Chapter 1, §10.1.1 for more information regarding claims filing jurisdiction.

Item 32b - 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 - Item 33b is not generally reported. However, for some Medicare policies you may be instructed to use this item; direction as to how to use this item will be in the instructions you received regarding the specific policy, if applicable.

20 - Patient's Request for *Medical* Payment Form CMS-1490S

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

The CMS implemented a new version of the Form CMS-1490S effective January 1, 2019. The revised form is version 01/18, OMB control number 0938-1197. The revised form will replace the previous version of the form 01/05, OMB control number 0938-0999.

The term, "Form CMS-1490S" refers to the form generically, independent of a given version. Medicare will conduct a dual-use period (January 1, 2019 through March 31, 2019) during which Beneficiaries (or their representatives) can send Medicare claims on either the old or the revised form. When the dual-use period is over, Medicare will accept beneficiary paper claims on only the revised Form CMS-1490S, version 01/18.

This form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains *the patient's* comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Some enrollees may want to keep the original itemized physician and supplier bills for income tax or complementary insurance purposes.

Photocopies of itemized bills are acceptable for Medicare deductible and payment purposes if there is no evidence of alteration. Social Security offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims.

Although §1848(g)(4) of the Act requires physicians and suppliers to submit Part B Medicare claims for services furnished on or after September 1, 1990, contractors continue to accept, process, and pay for covered services submitted by beneficiaries on a Form CMS-1490S if there is no clear indication that the service provider intends to file a claim. An itemized bill for services on or after September 1, 1990, which clearly indicates the physician or supplier intends to file a Part B claim for the patient, may be returned to the beneficiary.

For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so or if one of the following situations applies:

- DME purchases from private sources;
- Cases in which a physician/supplier does not possess information essential for filing an MSP claim. Assume this is the case if the beneficiary files an MSP claim and encloses the primary insurer's payment determination notice and there is no indication that the service provider was asked to file but refused to do so;
- Services paid under the indirect payment procedure;
- Foreign claims;
- Services furnished by sanctioned physicians and suppliers which are approved for payment to the beneficiary per the Program Integrity Manual (PIM); and
- Other unusual or unique situations that are evaluated on a case-by-case basis.

If the contractor approves 11 or more Form CMS-1490S claims in a calendar month for services performed on or after September 1, 1990, by the same physician or supplier, monitor the provider's claims submissions and take appropriate action.

The contractor continues to stock Form CMS-1490S and, upon request, furnish beneficiaries with these forms. (Beneficiaries need these forms to file claims for services that physicians/suppliers are not required to submit (e.g., services prior to September 1, 1990), or refuse to submit to Part B on their behalf.)

Medicare Claims Processing Manual
Chapter 31 - ANSI X12 Formats Other than Claims or Remittance

10.2 -Eligibility Connectivity Workflow

(Rev.: 4388; Issued: 09-06-19; Effective: 10-07-19; Implementation: 10-07-19)

In 2006, the Centers for Medicare & Medicaid Services (CMS) implemented the *HETS (HIPAA Eligibility Transaction System (HETS 270/271))* application to address the standards for the Medicare beneficiary eligibility inquiries, creating a centralized ASC X12 270/271 health care eligibility inquiry that provides eligibility transaction on a real-time basis:

1. Submitters may access the HETS 270/271 application in the CMS Baltimore Data Center using the CMS Extranet or by establishing internet connectivity using Simple Object Access Protocol (SOAP) + Web Services Description Language (WSDL) envelope standards hereafter referred to simply as SOAP or Hypertext Transfer Protocol (HTTP)/Multipurpose Internet Mail Extensions (MIME) Multi-part envelope standards hereafter referred to simply as MIME.

   The CMS Extranet is a secure, closed, private network currently used to transmit data between CMS and CMS Business Partners. Connections using SOAP or MIME are secured by the use and verification of Digital Certificates.

   For an ASC X12 270 real-time eligibility inquiry, the software at the CMS Baltimore Data Center will translate the incoming ASC X12 270 transaction, perform validations, request beneficiary eligibility information from the CMS eligibility database, and create either an ASC X12 271eligibility response, ASC X12 999 implementation acknowledgment, ASC X12 TA1 interchange acknowledgment or proprietary response.

2. For more information regarding the HETS application, visit the HETS Help web site. This web site is designed to provide technical system support to CMS Business Partners for the initiation, implementation, and operation of the HETS 270/271 application - Extranet or Internet Transaction Submission. This information is provided to assist external Business Partners with connectivity, testing, and data exchange with CMS and to keep users informed of any system issues that may arise.

http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html