

<b>CMS Manual System</b>	<b>Department of Health &amp; Human Services (DHHS)</b>
<b>Pub 100-04 Medicare Claims Processing</b>	<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>
<b>Transmittal 2162</b>	<b>Date: February 22, 2011</b>
	<b>Change Request 7018</b>

**NOTE TO CONTRACTORS: Transmittal 2124, dated December 23, 2010, is being rescinded and replaced with Transmittal 2162 dated February 22, 2011, which corrects compatibility errors in the Internet Only Manual revisions. All other information remains the same.**

**SUBJECT: Updates to the Internet Only Manual Pub. 100-04, Chapter 1 - General Billing Requirements, Chapter 15 - Ambulance, and Chapter 26 - Completing and Processing Form CMS-1500 Data Set**

**I. SUMMARY OF CHANGES:** An update to Publication (Pub.) 100-04, Chapter 15 by CMS Change Request 6621, Transmittal 1821, issued on September 25, 2009, mistakenly indicated in Section 30.1.2 that the ZIP Code point-of-pickup of an ambulance trip be reported on a CMS-1500 claim form in Item 32. This CR will correct that mistake in Chapter 15 as well as add similar claims billing instructions to Chapters 1 and 26. New version 5010 837P billing requirements that a diagnosis code as well as the ambulance trip's destination information be included on the electronic claim for ambulance services are being included as well. Finally, language falsely indicating that ambulance suppliers do not bill on Form CMS-1500 has been removed from Chapter 26, Section 10.

Also, the recently enacted Affordable Care Act contains provisions extending several ambulance payment rate bonuses. This CR amends Chapter 15 - Ambulance to reflect these statutory extensions.

**EFFECTIVE DATE: March 21, 2011**

**IMPLEMENTATION DATE: March 21, 2011**

*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-

<b>R/N/D</b>	<b>CHAPTER / SECTION / SUBSECTION / TITLE</b>
R	1 / 80.3.2.1.3 / Carrier Specific Requirements for Certain Specialties/Services
R	15 / 20.1.4 / Components of the Ambulance Fee Schedule
R	15/ 20.1.5.1 / CMS Supplied National ZIP Code File and National Ambulance Fee Schedule File
R	15 / 30.1.2 / Coding Instructions for Paper and Electronic Claim Forms
R	26 / 10 / Health Insurance Claim Form CMS-1500
R	26 / 10.4 / Items 14-33 - Provider of Service or Supplier Information

### **III. FUNDING:**

#### **For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:**

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

#### **For Medicare Administrative Contractors (MACs):**

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

### **IV. ATTACHMENTS:**

#### **Business Requirements**

#### **Manual Instruction**

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

# Attachment - Business Requirements

**NOTE TO CONTRACTORS: Transmittal 2124, dated December 23, 2010, is being rescinded and replaced with Transmittal 2162, dated February 22, 2011. which corrects compatibility errors in the Internet Only Manual revisions. All other information remains the same.**

<b>Pub. 100-04</b>	<b>Transmittal:2162</b>	<b>Date: February 22, 2011</b>	<b>Change Request: 7018</b>
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**SUBJECT: Updates to the Internet Only Manual, Pub. 100-04, Chapter 1 – General Billing Requirements, Chapter 15 – Ambulance, and Chapter 26 – Completing and Processing Form CMS-1500 Data Set**

**Effective Date: March 21, 2011**

**Implementation Date: March 21, 2011**

## I. GENERAL INFORMATION

**A. Background:** An update to Pub. 100-04, chapter 15, by CMS Change Request (CR) 6621, Transmittal 1821, issued on September 25, 2009, mistakenly indicated in Section 30.1.2 that the ZIP Code of the point-of-pickup of an ambulance trip must be reported on a Form CMS-1500 claim form in Item 32. This CR amends chapter 15 to correctly specify that Item 23 is the correct field for reporting the ZIP Code of the point-of-pickup of an ambulance trip as well as add this claims billing instruction to chapters 1 and 26.

If entities billing for ambulance services choose to submit claims in the 5010 837P electronic claim format on or after January 1, 2011, they must comply with the requirement that a diagnosis code be included on the claim. The CMS will not be capable of accepting claims submitted under the 5010 version of the 837P that do not comply with this requirement. (See MLN Matters article Transmission Number: SE1029, released 9/24/10.) In addition, the loaded ambulance trip’s destination information will be required on the 5010 837P electronic claim format. This CR will amend chapter 15 to include these instructions.

Also, the recently enacted Affordable Care Act of 2010 extended previously expired ambulance payment provisions allowing for increased payment amounts for both air and ground ambulance transports originating in rural and urban areas for claims with dates of service through December 31, 2010. This CR amends Pub.100-04, Medicare Claims Processing Manual, chapter 15, to reflect these statutory extensions.

**B. Policy:** This transmittal communicates revisions to chapter 1, General Billing Requirements, chapter 15, Ambulance, and chapter 26, Completing and Processing the Form CMS-1500 Data Set of Pub.100-04, Medicare Claims Processing Manual.

## II. BUSINESS REQUIREMENTS TABLE

*“Shall” denotes a mandatory requirement*

Number	Requirement	Responsibility (place an “X” in each applicable column)
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		A / B  M A C	D M M A C	F I  I E R	C A R R I E R	R H R I	Shared-System Maintainers				O T H E R
							F	M	V	C	
							I S S	I C S	M S	W F	
7018.1	Contractors shall be in compliance with the instructions found in Pub. 100-04, Medicare Claims Processing Manual, chapter 1, chapter 15, and chapter 26.	X		X	X						

### III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B  M A C	D M M A C	F I  I E R	C A R R I E R	R H R I	Shared-System Maintainers				O T H E R
							F	M	V	C	
I S S	I C S	M S	W F								
7018.2	<p>A provider education article related to this instruction will be available at <a href="http://www.cms.hhs.gov/MLNMattersArticles/">http://www.cms.hhs.gov/MLNMattersArticles/</a> shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.</p> <p>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.</p>	X		X	X						

### IV. SUPPORTING INFORMATION

#### Section A:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
7018.3	Sec. 3105 and 10311 of the Patient Protection and Affordable Care Act of 2010

**Section B: N/A**

## **V. CONTACTS**

**Pre-Implementation Contact(s):** Contact Eric Coulson by phone at (410)786-3352 or by email at [Eric.Coulson@cms.hhs.gov](mailto:Eric.Coulson@cms.hhs.gov)

**Post-Implementation Contact(s):** Contact Eric Coulson by phone at (410)786-3352 or by email at [Eric.Coulson@cms.hhs.gov](mailto:Eric.Coulson@cms.hhs.gov)

## **VI. FUNDING**

### **Section A:**

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

### **Section B:**

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.

# Medicare Claims Processing Manual

## Chapter 1 - General Billing Requirements

### **80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services** *(Rev.2162, Issued: 02-22-11, Effective: 03-21-11, Implementation: 03-21-11)*

Carriers must return the following claim as unprocessable to the provider of service/supplier:

a. For chiropractor claims:

1. If the x-ray date is not entered in item 19 for claims with dates of service prior to January 1, 2000. Entry of an x-ray date is not required for claims with dates of service on or after January 1, 2000.
2. If the initial date “actual” treatment occurred is not entered in item 14. (Remark code MA122 is used.)

b. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and the group’s name, address, ZIP Code, and PIN number, until the NPI is required, is not entered in item 33 or if the NPI is not entered in item 33a. of the Form CMS-1500 (8/05) when the NPI is required or, until the NPI is required, if their personal PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required. (Remark code MA112 is used.)

c. For durable medical, orthotic, and prosthetic claims, if the name, address, and ZIP Code of the location where the order was accepted were not entered in item 32. (Remark code MA 114 is used.)

d. For physicians who maintain dialysis patients and receive a monthly capitation payment:

1. If the physician is a member of a professional corporation, similar group, or clinic, and, until the NPI is required, the attending physician’s PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required). (Remark code N290 is used.)
2. If the name, address, and ZIP Code of the facility other than the patient’s home or physician’s office involved with the patient’s maintenance of care and training is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

e. For routine foot care claims, if the date the patient was last seen and the attending physician's PIN (or NPI when required) is not present in item 19. (Remark code N324 or N253 is used.)

f. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name is not present in items 17 or 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N264 or N286 is used.)

g. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his or her name is not present in items 17 or in 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N264 or N286 is used.)

h. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office (including services to a patient in an institution), if the name, address, and ZIP Code of the location where services were performed is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

i. For independent laboratory claims:

1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician that any laboratory service(s) performed were conducted at home or in an institution by entering the appropriate annotation in item 19 (i.e., "Homebound"). (Remark code MA116 is used.)

2. If the name, address, and ZIP Code where the test was performed is not entered in item 32, if the services were performed in a location other than the patient's home or physician's office. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

3. When a diagnostic service is billed as a purchased service and the service is purchased from another billing jurisdiction, the billing provider must submit their own NPI in Item 32a with the name, address, and ZIP Code of the performing provider in Item 32. If Item 32 and 32a are not entered, remark code MA114 is used.

j. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their 6-digit, FDA-approved certification number in item 32 when billing the technical or global component. (Remark code MA128 is used.)

k. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name is not present in item 17 or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N264 or N286 is used.)

l. For portable x-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or NPI is not entered in items 17 or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N264 or N286 is used.)

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist's name, if appropriate, is not entered in items 17 NPI is not entered in item 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N264 or N286 is used.)

n. For outpatient physical or occupational therapy services provided by a qualified, independent physical, or occupational therapist, Medicare policy does not require the date last seen by a physician, or NPI, of such physician. Medicare policy does not require identification of the ordering, referring or certifying physician on outpatient therapy claims, including speech-language pathology service claims. However, providers and suppliers are required to comply with applicable HIPAA ASC X12 837 claim completion requirements. (See Pub. 100-04, chapter 5, §20 and Pub. 100-02, chapter 15, §§220 and 230 for therapy service policies.) Deletion of this claim requirement for outpatient therapy services does not apply to the requirements for the date last seen and the NPI of the ordering and supervising physician/nonphysician practitioner for therapy services provided incident to the services of a physician, because the incident to policies continue to require them.

1. If the UPIN (or NPI when required) of the attending physician is not present in item 19. (Remark code N253 is used.)

2. If the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen by the attending physician is not present in item 19. (Remark code N324 is used.)

o. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP Code, and PIN (until the NPI is required) where the laboratory services were performed in item 32 or if the NPI is not entered into item 32a. of the Form CMS-1500 (8/05) when the NPI is required), if the services were performed at a location other than the place of service home – 12. (Use Remark code MA114.)

p. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998. (Remark code MA120 is used.)

q. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23, for dates of service through March 31, 2008. (Remark code MA50 is used.) With the use of new modifier Q0, effective for dates of service on and after April 1, 2008, contractors will no longer be able to distinguish an IDE claim from other investigational clinical services. Therefore this edit will no longer apply.

r. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23. (Remark code MA49 is used.)

s. For Competitive Acquisition Program drug and biological claims, in accordance with the instructions found in the Medicare Claims Processing Manual, chapter 17, section 100.2.1 – section 100.9.

t. For claims for artificial hearts covered by Medicare under an approved clinical trial, if procedure code 0051T is entered in Item 24D, and an 8-digit clinical trial number that matches an approved clinical trial listed at:

[http://www.cms.hhs.gov/MedicareApprovedFacilitie/06\\_artificialhearts.asp#TopOfPage](http://www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp#TopOfPage) is not entered in Item 19; and the HCPCS modifier Q0 is not entered on the same line as the procedure code in Item 24D, and the diagnosis code V70.7 is not entered in Item 21 and linked to the same procedure code. (As appropriate, use remark code MA97 – Missing/ incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number; M64 – Missing/incomplete/invalid other diagnosis; or claim adjustment reason code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.)

u. For clinical trial claims processed **after September 28, 2009**, with dates of service on or after January 1, 2008, claims submitted with either the modifier QV or the modifier Q1, if the diagnosis code V70.7 is not submitted with the claim.

*v. For ambulance claims, claims submitted without the ZIP Code of the loaded ambulance trip's point-of-pickup in Item 23 of the CMS-1500 Form.*

# Medicare Claims Processing Manual

## Chapter 15 – Ambulance

### ***20.1.4 - Components of the Ambulance Fee Schedule***

***(Rev2162, Issued: 02-22-11, Effective: 03-21-11, Implementation: 03-21-11.)***

The mileage rates provided in this section are the base rates that are adjusted by the yearly ambulance inflation factor (AIF). The payment amount under the fee schedule is determined as follows:

- **For ground ambulance services**, the fee schedule amount includes:
  1. A money amount that serves as a nationally uniform base rate, called a “conversion factor” (CF), for all ground ambulance services;
  2. A relative value unit (RVU) assigned to each type of ground ambulance service;
  3. A geographic adjustment factor (GAF) for each ambulance fee schedule locality area (geographic practice cost index (GPCI));
  4. A nationally uniform loaded mileage rate;
  5. An additional amount for certain mileage for a rural point-of-pickup; and
  6. For specified temporary periods, certain additional payment amounts as described in section 20.1.4A, below.
- **For air ambulance services**, the fee schedule amount includes:
  1. A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;
  2. A geographic adjustment factor (GAF) for each ambulance fee schedule locality area (GPCI);
  3. A nationally uniform loaded mileage rate for each type of air service; and
  4. A rural adjustment to the base rate and mileage for services furnished for a rural point-of-pickup.

#### **A. Ground Ambulance Services**

## 1. Conversion Factor

The conversion factor (CF) is a money amount used to develop a base rate for each category of ground ambulance service. The CF is updated annually by the ambulance inflation factor and for other reasons as necessary.

## 2. Relative Value Units

Relative value units (RVUs) set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service. The different payment amounts are based on level of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service, e.g., BLS has an RVU of 1; higher RVU values are assigned to the other types of ground ambulance services, which require more service than BLS.

The RVUs are as follows:

Service Level	RVU
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20
ALS1- Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

## 3. Geographic Adjustment Factor (GAF)

The GAF is one of two factors intended to address regional differences in the cost of furnishing ambulance services. The GAF for the ambulance FS uses the non-facility practice expense (PE) of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences. Thus, the geographic areas applicable to the ambulance FS are the same as those used for the physician fee schedule.

The location where the beneficiary was put into the ambulance (POP) establishes which GPCI applies. For multiple vehicle transports, each leg of the transport is separately

evaluated for the applicable GPCI. Thus, for the second (or any subsequent) leg of a transport, the POP establishes the applicable GPCI for that portion of the ambulance transport.

For ground ambulance services, the applicable GPCI is multiplied by 70 percent of the base rate. Again, the base rate for each category of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to the ground mileage rate.

#### **4. Mileage**

In the context of all payment instructions, the term “mileage” refers to loaded mileage. The ambulance FS provides a separate payment amount for mileage. The mileage rate per statute mile applies for all types of ground ambulance services, except Paramedic Intercept, and is provided to all Medicare contractors electronically by CMS as part of the ambulance FS. Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item.

#### **5. Adjustment for Certain Ground Mileage for Rural Points of Pickup (POP)**

The payment rate is greater for certain mileage where the POP is in a rural area to account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period.

If the POP is a rural ZIP Code, the following calculations should be used to determine the rural adjustment portion of the payment allowance. For loaded miles 1-17, the rural adjustment for ground mileage is 1.5 times the rural mileage allowance.

For services furnished during the period July 1, 2004 through December 31, 2008, a 25 percent increase is applied to the appropriate ambulance FS mileage rate to each mile of a transport (both urban and rural POP) that exceeds 50 miles (i.e., mile 51 and greater).

The following chart summarizes the above information:

<b>Service</b>	<b>Dates of Service</b>	<b>Bonus</b>	<b>Calculation</b>
Loaded miles 1-17, Rural POP	Beginning 4/1/02	50%	FS Rural mileage * 1.5
Loaded miles 18- 50, Rural POP	4/1/02 – 12/31/03	25%	FS Rural mileage * 1.25
All loaded miles (Urban or Rural POP) 51+	7/1/04 – 12/31/08	25%	FS Urban or Rural mileage * 1.25

The POP, as identified by ZIP Code, establishes whether a rural adjustment applies to a particular service. Each leg of a multi-leg transport is separately evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the ZIP Code of the POP establishes whether a rural adjustment applies to such second (or subsequent) transport.

For the purpose of all categories of ground ambulance services except paramedic intercept, a rural area is defined as a U.S. Postal Service (USPS) ZIP Code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or in New England, a New England County Metropolitan Area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the “Goldsmith modification.” (The Goldsmith modification establishes an operational definition of rural areas within large counties that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical features that they are more rural than urban in character and lack easy geographic access to health services.)

For Paramedic Intercept, an area is a rural area if:

- It is designated as a rural area by any law or regulation of a State;
- It is located outside of an MSA or NECMA; or
- It is located in a rural census tract of an MSA as determined under the most recent Goldsmith modification.

See IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 – Ambulance Services, section 30.1.1 – Ground Ambulance Services for coverage requirements for the Paramedic Intercept benefit. Presently, only the State of New York meets these requirements.

Although a transport with a POP located in a rural area is subject to a rural adjustment for mileage, Medicare still pays the lesser of the billed charge or the applicable FS amount for mileage. Thus, when rural mileage is involved, the contractor compares the calculated FS rural mileage payment rate to the provider’s/supplier’s actual charge for mileage and pays the lesser amount.

The CMS furnishes the ambulance FS files to claims processing contractors electronically. A version of the Ambulance Fee Schedule is also posted to the CMS website ([http://www.cms.hhs.gov/AmbulanceFeeSchedule/02\\_afspuf.asp](http://www.cms.hhs.gov/AmbulanceFeeSchedule/02_afspuf.asp)) for public consumption. To clarify whether a particular ZIP Code is rural or urban, please refer to the most recent version of the Medicare supplied ZIP Code file.

## **6. Regional Ambulance FS Payment Rate Floor for Ground Ambulance Transports**

For services furnished during the period July 1, 2004 through December 31, 2009, the base rate portion of the payment under the ambulance FS for ground ambulance transports is subject to a minimum amount. This minimum amount depends upon the area of the country in which the service is furnished. The country is divided into 9 census

divisions and each of the census divisions has a regional FS that is constructed using the same methodology as the national FS. Where the regional FS is greater than the national FS, the base rates for ground ambulance transports are determined by a blend of the national rate and the regional rate in accordance with the following schedule:

<b>Year</b>	<b>National FS Percentage</b>	<b>Regional FS Percentage</b>
7/1/04 - 12/31/04	20%	80%
CY 2005	40%	60%
CY 2006	60%	40%
CY 2007 – CY 2009	80%	20%
CY 2010 and thereafter	100%	0%

Where the regional FS is not greater than the national FS, there is no blending and only the national FS applies. Note that this provision affects only the FS portion of the blended transition payment rate. This floor amount is calculated by CMS centrally and is incorporated into the FS amount that appears in the FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the Medicare B/MAC or A/MAC in order to implement this provision.

### **7. Adjustments for FS Payment Rate for Certain Rural Ground Ambulance Transports**

For services furnished during the period July 1, 2004 through December 31, 2010, the base rate portion of the payment under the FS for ground ambulance transports furnished in certain rural areas is increased by a percentage amount determined by CMS centrally. This increase applies if the POP is in a rural county (or Goldsmith area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. CMS will determine this bonus amount and the designated POP rural ZIP Codes in which the bonus applies. Beginning on July 1, 2004, rural areas qualifying for the additional bonus amount will be identified with a “B” indicator on the national ZIP Code file. Contractors must apply the additional rural bonus amount as a multiplier to the base rate portion of the FS payment for all ground transports originating in the designated POP ZIP Codes.

### **8. Adjustments for FS Payment Rates for Ground Ambulance Transports**

The payment rates under the FS for ground ambulance transports (both the fee schedule base rates and the mileage amounts) are increased for services furnished during the period July 1, 2004 through December 31, 2006 as well as July 1, 2008 through December 31, 2010. For ground ambulance transport services furnished where the POP

is urban, the rates are increased by 1 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 2 percent for claims with dates of service July 1, 2008 through December 31, 2010 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 *and Sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act (ACA) of 2010*. For ground ambulance transport services furnished where the POP is rural, the rates are increased by 2 percent for claims with dates of service July 1, 2004 through December 31, 2006 in accordance with Section 414 of the Medicare Modernization Act (MMA) of 2004 and by 3 percent for claims with dates of service July 1, 2008 through December 31, 2010 in accordance with Section 146(a) of the Medicare Improvements for Patients and Providers Act of 2008 *and Sections 3105(a) and 10311(a) of the Patient Protection and Affordable Care Act (ACA) of 2010*. These amounts are incorporated into the fee schedule amounts that appear in the Ambulance FS file maintained by CMS and downloaded by CMS contractors. There is no calculation to be done by the Medicare carrier or intermediary in order to implement this provision.

The following chart summarizes the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 payment changes for ground ambulance services that became effective on July 1, 2004 as well as the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008 changes that became effective July 1, 2008 *and were extended by the Patient Protection and Affordable Care Act of 2010*:

Summary Chart of Additional Payments for Ground Ambulance Services Provided by MMA and MIPPA

<b>Service</b>	<b>Effective Dates</b>	<b>Payment Increase*</b>
All rural miles	7/1/04 - 12/31/06	2%
All rural miles	7/1/08 – 12/31/10	3%
Rural miles 51+	7/1/04 - 12/31/08	25% **
All urban miles	7/1/04 - 12/31/06	1%
All urban miles	7/1/08 – 12/31/10	2%
Urban miles 51+	7/1/04 - 12/31/08	25% **
All rural base rates	7/1/04 - 12/31/06	2%
All rural base rates	7/1/08 – 12/31/10	3%
Rural base rates (lowest quartile)	7/1/04 - 12/31/10	22.6 %**

<b>Service</b>	<b>Effective Dates</b>	<b>Payment Increase*</b>
All urban base rates	7/1/04 - 12/31/06	1%
All urban base rates	7/1/08 – 12/31/10	2%
All base rates (regional fee schedule blend)	7/1/04 - 12/31/09	Floor

**NOTES:** \* All payments are percentage increases and all are cumulative.

\*\*Contractor systems perform this calculation. All other increases are incorporated into the CMS Medicare Ambulance FS file.

## **B. Air Ambulance Services**

### **1. Base Rates**

Each type of air ambulance service has a base rate. There is no conversion factor (CF) applicable to air ambulance services.

### **2. Geographic Adjustment Factor (GAF)**

The GAF, as described above for ground ambulance services, is also used for air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50 percent of each of the base rates (fixed and rotary wing).

### **3. Mileage**

The FS for air ambulance services provides a separate payment for mileage.

### **4. Adjustment for Services Furnished in Rural Areas**

The payment rates for air ambulance services where the POP is in a rural area are greater than in an urban area. For air ambulance services (fixed or rotary wing), the rural adjustment is an increase of 50 percent to the unadjusted FS amount, e.g., the applicable air service base rate multiplied by the GAF plus the mileage amount or, in other words, 1.5 times both the applicable air service base rate and the total mileage amount.

The basis for a rural adjustment for air ambulance services is determined in the same manner as for ground services. That is, whether the POP is within a rural ZIP Code as described above for ground services.

### 20.1.5.1 - CMS Supplied National ZIP Code File and National Ambulance Fee Schedule File

*(Rev. 2162, Issued: 02-22-11, Effective: 03-21-11, Implementation: 03-21-11)*

CMS will provide each contractor with two files: a national ZIP Code file and a national Ambulance FS file.

A. The national ZIP5 Code file is a file of 5-digit USPS ZIP Codes that will map each ZIP Code to the appropriate FS locality. Every 2 months, CMS obtains an updated listing of ZIP Codes from the USPS. On the basis of the updated USPS file, CMS updates the Medicare ZIP Code file and makes it available to contractors.

The following is a record layout of the ZIP5 file effective January 1, 2009

#### ZIP5 CODE to LOCALITY RECORD LAYOUT

Field Name	Position	Format	COBOL Description
State	1-2	X(02)	Alpha State Code
ZIP Code	3-7	X(05)	Postal ZIP Code
Carrier	8-12	X(05)	Medicare Part B Carrier Number
Pricing Locality	13-14	X(02)	Pricing Locality
Rural Indicator	15	X(01)	Effective 1/1/07  Blank = urban, R=rural, B=super rural
Beneficiary Lab CB Locality	16-17	X(02)	Lab competitive bid locality;  Z1= CBA1  Z2= CBA2  Z9= Not a demonstration locality

Rural Indicator 2	18	X(01)	What was effective 12/1/06 Blank=urban, R=rural, B=super rural
Filler	19-20	X(02)	
Plus Four Flag	21	X(01)	0 = no +4 extension  1 = +4 extension
Filler	22-75	X(54)	
Year/Quarter	76-80	X(05)	YYYYQ

**NOTE:** Effective October 1, 2007, claims for ambulance services will continue to be submitted and priced using 5-digit ZIP Codes. Contractors will not need to make use of the ZIP9 file for ambulance claims.

Beginning in 2009, contractors shall maintain separate ZIP Code files for each year which will be updated on a quarterly basis. Claims shall be processed using the correct ZIP Code file based on the date of service submitted on the claim.

A ZIP Code located in a rural area will be identified with either a letter “R” or a letter “B.” Some ZIP Codes will be designated as rural due to the Rural Urban Commuting Area (RUCA) Score even though the ZIP Code may be located, in whole or in part, within an MSA or Core Based Statistical Area (CBSA).

A “B” designation indicates that the ZIP Code is in a rural county (or RUCA area) that is comprised by the lowest quartile by population of all such rural areas arrayed by population density. Effective for claims with dates of service between July 1, 2004 and December 31, 2010, contractors must apply a bonus amount to be determined by CMS to the base rate portion of the payment under the FS for ground ambulance services with a POP “B” ZIP Code. This amount is in addition to the rural bonus amount applied to ground mileage for ground transports originating in a rural POP ZIP Code.

Each calendar quarter beginning October 2007, CMS will upload updated ZIP5 and ZIP9 ZIP Code files to the Direct Connect (formerly the Network Data Mover). Contractors shall make use of the ZIP5 file for ambulance claims and the ZIP9 file as appropriate per IOM Pub. 100-04, Medicare Claims Processing Manual, chapter 1 –General Billing Requirements, section 10.1.1.1 - Payment Jurisdiction Among Local Carriers for Services Paid Under the Physician Fee Schedule and Anesthesia Services and the additional information found in Transmittal 1193, Change Request 5208, issued March 9, 2007. The updated files will be available for downloading on approximately November 15th for the January 1 release, approximately February 15th for the April 1 release,

approximately May 15th for the July 1 release, and approximately August 15th for the October 1 release.

Contractors are responsible for retrieving the ZIP Code files upon notification and must implement the following procedure for retrieving the files:

1. Upon quarterly Change Requests communicating the availability of updated ZIP Code files, go to the Direct Connect and search for the files. Confirm that the release number (last 5 digits) corresponds to the upcoming calendar quarter. If the release number (last 5 digits) does not correspond to the upcoming calendar quarter, notify CMS.
2. After confirming that the ZIP Code files on the Direct Connect corresponds to the next calendar quarter, download the files and incorporate the files into your testing regime for the upcoming model release.

The names of the files will be in the following format:

MU00.AAA2390.ZIP5.LOCALITY.Vyyyyr and MU00.AAA2390.ZIP9.LOCALITY.Vyyyyr where “yyyy” equals the calendar year and “r” equals the release number with January =1, April =2, July =3, and October =4. So, for example, the names of the file updates for October 2007 are MU00.AAA2390.ZIP5.LOCALITY.V20074 and MU00.AAA2390.ZIP9.LOCALITY.V20074. The release number for this file is 20074, release 4 for the year 2007.

When the updated files are loaded to the Direct Connect, they will overlay the previous ZIP Code files.

**NOTE:** Even the most recently updated ZIP Code files will not contain ZIP Codes established by the USPS after CMS compiles the files. Therefore, for ZIP Codes reported on claims that are not on the most recent ZIP Code files, follow the instructions for new ZIP Codes in **§20.1.5(B)**.

**B.** CMS will also provide contractors with a national Ambulance FS file that will contain payment amounts for the applicable HCPCS codes. The file will include FS payment amounts by locality for all FS localities. The FS file will be available via the CMS Mainframe Telecommunications System. Contractors are responsible for retrieving this file when it becomes available. The full FS amount will be included in this file. CMS will notify contractors of updates to the FS and when the updated files will be available for retrieval. CMS will send a full-replacement file for annual updates and for any other updates that may occur.

The following is a record layout of the Ambulance Fee Schedule file:

**AMBULANCE FEE SCHEDULE FILE RECORD DESCRIPTION**

<b>Field Name</b>	<b>Position</b>	<b>Format</b>	<b>Description</b>
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<b>Field Name</b>	<b>Position</b>	<b>Format</b>	<b>Description</b>
HCPCS	1-5	X(05)	Healthcare Common Procedure Coding System
Carrier Number	6-10	X(05)	
Locality Code	11-12	X(02)	
Base RVU	13-18	s9(4)v99	Relative Value Unit
Non-Facility PE GPCI	19-22	s9v9(3)	Geographic Adjustment Factor
Conversion Factor	23-27	s9(3)v99	Conversion Factor
Urban Mileage/Base Rate	28-34	s9(5)v99	Urban Payment Rate or Mileage Rate (determined by HCPCS)
Rural Mileage/Base Rate	35-41	s9(5)v99	Rural Payment Rate or Mileage Rate (determined by HCPCS)
Current Year	42-45	9(04)	YYYY
Current Quarter	46	9(01)	Calendar Quarter – value 1-4
Effective Date*	47-54	9(8)	Effective date of the fee schedule file (MMDDYYYY)
Filler	55-80	X(26)	Future use

\*Beginning on July 1, 2004, CMS will add an effective date field to the Ambulance Fee Schedule File in the filler area of the file.

### **30.1.2 - Coding Instructions for Paper and Electronic Claim Forms** *(Rev. 2162, Issued: 02-22-11, Effective: 03-21-11, Implementation: 03-21-11)*

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

In item 23 of the CMS-1500 Form, billers shall code the 5-digit ZIP Code of the point of pickup.

Electronic billers using ANSI X12N 837 should refer to the Implementation Guide to determine how to report the origin information (e.g., the ZIP Code of the point of pickup). *Beginning with the early implementation of the version 5010 837P claim format on January 1, 2011, electronic billers will be required to submit, in addition to the loaded ambulance trip's origin information (e.g., the ZIP Code of the point of pickup), the loaded ambulance trip's destination information (e.g., the ZIP code of the point of drop-off). Again, please refer to the appropriate Implementation Guide to determine how to report the destination information. It is important to remember that only the ZIP Code of the point of pickup will be used to adjudicate and price the ambulance claim, not the point of drop-off, but that the point of drop-off will be an additional reporting requirement on the version 5010 837P claim format.*

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

Claims without a ZIP Code in item 23 on *the* CMS-1500 Form item 23, or with multiple ZIP Codes in item 23, must be returned as unprocessable. Carriers use message N53 on the remittance advice in conjunction with reason code 16.

ZIP Codes must be edited for validity.

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

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

Beginning with dates of service on or after January 1, 2011, if mileage is billed it must be reported as fractional units in Item 24G of the Form CMS-1500 paper claim or the corresponding loop and segment of the ANSI X12N 837P electronic claim for trips totaling up to 100 covered miles. When reporting fractional mileage, suppliers must round the total miles up to the nearest tenth of a mile and report the resulting number

with the appropriate HCPCS code for ambulance mileage. The decimal must be used in the appropriate place (e.g., 99.9).

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

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

Fractional mileage reporting applies only to ambulance services billed on a Form CMS-1500 paper claim, ANSI X12N 837P, or 837I electronic claims. It does not apply to providers billing on the Form CMS-1450.

For mileage HCPCS billed on a Form CMS-1500 or ANSI X12N 837P only, contractors shall automatically default to “0.1” units when the total mileage units are missing in Item 24G.

Ambulance suppliers submitting a claim using the CMS-1500 Form, or the electronic equivalent ANSI X12N 837, for an ambulance transport with more than one Medicare beneficiary onboard must use the “GM” modifier (“Multiple Patient on One Ambulance Trip”) for each service line item. In addition, suppliers are required to submit to B/MACs / Carriers documentation to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim (HIC) numbers for each Medicare beneficiary. B/MACs / Carriers shall calculate payment amounts based on policy instructions found in Pub.100-02, Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services, Section 10.3.10 – Multiple Patient Ambulance Transport.

*Ambulance claims submitted on or after January 1, 2011 in the version 5010 837P electronic claim format require the presence of a diagnosis code and the absence of said diagnosis code will cause the ambulance claim to not be accepted into the claims processing system. It is important to note that the presence of a diagnosis code on an ambulance claim is not required as a condition of ambulance payment policy. The adjudicative process does not take into account the presence (or absence) of a diagnosis code but the inclusion of a diagnosis code will be an additional reporting requirement on the version 5010 837P claim format.*

# Medicare Claims Processing Manual

## Chapter 26 - Completing and Processing Form CMS-1500 Data Set

### 10 - Health Insurance Claim Form CMS-1500

*(Rev. 2162, Issued: 02-22-11, Effective: 03-21-11, Implementation: 03-21-11)*

The current version of the form is Form CMS-1500 (08/05) and is approved under the OMB collection 0938-0999. The Form CMS-1500 (Health Insurance Claim Form) is sometimes referred to as the AMA (American Medical Association) form. The Form CMS-1500 is the prescribed form for claims prepared and submitted by physicians or suppliers, whether or not the claims are assigned.

Carriers, physicians, and suppliers are responsible for purchasing their own Form CMS-1500 forms. Forms can be obtained from printers or printed in-house as long as they follow the CMS approved specifications (see section 30) developed by the American Medical Association. Photocopies of the Form CMS-1500 are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the Form CMS-1500 for processing. To purchase forms from the U.S. Government Printing Office, call (202) 512-1800.

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare and Medicaid programs for claims from physicians and suppliers. It has also been adopted by the TRICARE Program and has received the approval of the American Medical Association (AMA) Council on Medical Services.

There are a number of Part B services that have special limitations on payments or that require special methods of benefit computation. Carriers or A/B MACs should monitor their processing systems to insure that they recognize the procedure codes that involve services with special payment limitations or calculation requirements. They should be able to identify separately billed procedure codes for physician services which are actually part of a global procedure code to prevent a greater payment than if the procedure were billed globally.

The following instructions must be completed or are required for a Medicare claim. Carriers or A/B MACs should provide information on completing the Form CMS-1500 to all physicians and suppliers in their area at least once a year.

Providers may use these instructions to complete this form. The Form CMS-1500 has space for physicians and suppliers to provide information on other health insurance. This information can be used by carriers or A/B MACs to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment, or whether there is another insurer to which Medicare can forward billing and payment data following adjudication if the provider is a physician or supplier that participates in

Medicare. (See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3, and chapter 28 of this manual).

Providers and suppliers must report 8-digit dates in all date of birth fields (items 3, 9b, and 11a), and either 6-digit or 8-digit dates in all other date fields (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

Providers and suppliers have the option of entering either a 6 or 8-digit date in items 11b, 14, 16, 18, 19, or 24a. However, if a provider of service or supplier chooses to enter 8-digit dates for items 11b, 14, 16, 18, 19, or 24a, he or she must enter 8-digit dates for all these fields. For instance, a provider of service or supplier will not be permitted to enter 8-digit dates for items 11b, 14, 16, 18, 19 and a 6-digit date for item 24a. The same applies to providers of service and suppliers who choose to submit 6-digit dates too. Items 12 and 31 are exempt from this requirement.

<b>Legend</b>	<b>Description</b>
MM	Month (e.g., December = 12)
DD	Day (e.g., Dec15 = 15)
YY	2 position Year (e.g., 1998 = 98)
CCYY	4 position Year (e.g., 1998 = 1998)
(MM   DD   YY) or (MM   DD   CCYY)	A space must be reported between month, day, and year (e.g., 12   15   98 or 12   15   1998). This space is delineated by a dotted vertical line on the Form CMS-1500)
(MMDDYY) or (MMDDCCYY)	No space must be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

#### **10.4 - Items 14-33 - Provider of Service or Supplier Information** *(Rev. 2162, Issued: 02-22-11, Effective: 03-21-11, Implementation: 03-21-11)*

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

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

**Item 15** - Leave blank. Not required by Medicare.

**Item 16** - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is

unable to work. An entry in this field may indicate employment related insurance coverage.

**Item 17** - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

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

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;
2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;
3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 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;

**Item 17a** – Leave blank.

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

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

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

**Item 19** - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the NPI of his/her attending physician when a physician providing routine foot care submits claims.

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

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

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.

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

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

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

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

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

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

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

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

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

Enter the NPI 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 identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

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

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

**Item 20** - Complete this item when billing for diagnostic tests subject to 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 an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

**Item 22** - Leave blank. Not required by Medicare.

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

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

For physicians performing care plan oversight services, enter the 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 Form CMS-1500.

**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 location, using a place of service code, for each item used or service performed. This is a required field.

**NOTE:** When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.

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

**Item 24D** - Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

Return as unprocessable if an "unlisted procedure code" or an (NOC) code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment.

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

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

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

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

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

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

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

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 B/MAC 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** - Enter the ID qualifier 1C in the shaded portion.

**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** - Enter the name and address, and ZIP *code* of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name, address, and ZIP *code* of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and ZIP *code* may be entered in the block. If additional entries are needed, separate claim forms shall be submitted.

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 Form CMS-1500 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 carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP *code*.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DME MAC only). This field is required. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

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

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

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

**Item 32b** - 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** - Effective May 23, 2008, Item 33b is not to be reported.