

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2041	Date: August 31, 2010
	Change Request 6947

NOTE: Transmittal 2015 dated July 30, 2010 is being rescinded and replaced by Transmittal 2041 dated August 31, 2010 to incorporate manual changes that were omitted from CR 6929, Transmittal 1970, Chapter 26, section 10.4. All other material remains the same.

SUBJECT: Revisions to Claims Processing Instructions for Services Rendered in Place of Service Home

I. SUMMARY OF CHANGES: This change requires that the address for where the service was provided be included, as required by the Internet Only Manual and the Implementation Guide for the 5010 version of the ANSI X12N 837 P electronic form, for services payable under the Medicare Physician Fee Schedule and anesthesia services when the Place of Service is Home. This change will be effective for claims processed on or after January 1, 2011.

EFFECTIVE DATE: For claims processed on or after January 1, 2011

IMPLEMENTATION DATE: January 3, 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/revise information only, and not the entire table of contents.

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	1/Table of Contents
R	1/10.1.1/Payment Jurisdiction Among Local B/MACs for Services Paid Under the Physician Fee Schedule and Anesthesia Services
R	1/10.1.1.1/Claims Processing Instructions for Payment Jurisdiction
R	1/80.3.2.1.1/Carrier Data Element Requirements
R	1/80.3.2.1.2/Conditional Data Element Requirements for Carriers and DMERCs
R	26/10.4/Items 14-33 - Provider of Services 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

Pub. 100-04	Transmittal: 2041	Date: August 31, 2010	Change Request: 6947
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NOTE: Transmittal 2015 dated July 30, 2010 is being rescinded and replaced by Transmittal 2041 dated August 31, 2010 to incorporate manual changes that were omitted from CR 6929, Transmittal 1970, Chapter 26, section 10.4. All other material remains the same.

SUBJECT: Revisions to Claims Processing Instructions for Services Rendered in Place of Service Home

Effective Date: For claims processed on or after January 1, 2011

Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background: The 5010 version of the ANSI X12 N 837 P format will be available for use on January 1, 2011. Claims submitted on the 5010 format will require that the location where the service was rendered be submitted when the location of the health care service is different than that carried in Loop ID-2010AA (Billing Provider). Since the address for place of service home, (or any other places of service that the contractors consider to be home), will never be the same as the billing provider’s address, the facility service location will be required in that situation.

Claims that continue to be submitted on the 4010A1 version will continue to be processed according to the rules for 4010A1.

Claims processed on or after January 1, 2011 that are submitted on the Form CMS-1500 for services payable under the MPFS, as well as anesthesia services, shall be required to include the address of where the service was performed on the claim.

To determine payment jurisdiction, contractors shall continue to process the 4010A1 format claims using the ZIP code from the beneficiary eligibility file. For claims processed on or after January 1, 2011, to determine payment jurisdiction, contractors shall process paper claims and 5010 format claims using the ZIP code included for the address of where the service was performed on the claim. For electronic claims, this address may be found in different loops of the claim depending upon the requirements of the Implementation Guide.

B. Policy: This CR represents no change to payment policy.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)						
		A	D	F	C	R	Shared-	OTH
		/	M	I	A	H	System	ER
		B	E		R	H	Maintainers	

		M A C	M A C		R I E R	I	F I S S	M C S	V M S	C W F	
6947.1	For claims processed on or after January 1, 2011 on the 5010 version of the ANSI X12N 837 P electronic claim form, contractors shall return as unprocessable claims for services payable under the MPFS and anesthesia services when rendered in POS home (or any POS they consider home) if submitted without the service facility location.	X			X			X			
6947.1.1	For claims processed on the CMS-1500 paper claim form on or after January 1, 2011, contractors shall return as unprocessable claims for services payable under the MPFS and anesthesia service rendered in all POS (including home) if submitted without the address of where the service was performed in Item 32.	X			X			X			
6947.1.2	Contractors shall return the following Claims Adjustment Reason Code (CARC) and Remittance Advice Remark Codes (RARC) for the situations described in BRs 6947.1 and 6947.1.1: CARC 16 – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) RARC MA114 Missing/incomplete/invalid information on where the services were furnished. RARC MA130 – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	X			X						
6947.2	Contractors shall make no changes to requirements for claims submitted on the 4010A1 format as they pertain to POS home and determining pricing locality.	X			X			X			
6947.3	Effective for claims processed on or after January 1, 2011, contractors shall return as unprocessable claims on the Form CMS-1500 for services payable under the MPFS and anesthesia services when more than one POS code is on the claim.	X			X			X			
6947.3.1	Contractors shall return the following CARC and RARCs: CARC 16 – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPCP Reject Reason Code, or Remittance Advice	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R I E R	R H I I S S	Shared-System Maintainers				OTH ER
							F I S	M C S	V M S	C W F	
	Remark Code that is not an ALERT.) RARC M77 - Missing/incomplete/invalid place of service. RARC MA130 – Your claim contains incomplete and/or invalid information, no appeals rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.										
6947.4	For claims processed on or after January 1, 2011, to determine payment jurisdiction, contractors shall process paper claims and claims submitted in the 5010 format using the ZIP code included In Item 32 on the paper claim and in the appropriate loop on the electronic claim that represents where the service was performed according to the Implementation Guide.	X			X			X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R I E R	R H I I S S	Shared-System Maintainers				OTH ER
							F I S	M C S	V M S	C W F	
6947.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTH ER
		M A C	M A C				I S S	M S	V S	C W F	
	supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
	N/A

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Leslie Trazzi at leslie.trazzi@cms.hhs.gov.

Post-Implementation Contact(s): Appropriate Regional Office or A/B MAC Project Officer.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*, use only one of the following statements:

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

Section B: For *Medicare Administrative Contractors (MACs)*, include the following statement:

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

Table of Contents *(Rev. 2041, Issued 8-31-10)*

[Transmittals for Chapter 1](#)

Crosswalk to Old Manuals

10.1.1.1 - *Claims Processing Instructions for Payment Jurisdiction*

10.1.1 - Payment Jurisdiction Among Local B/MACs for Services Paid Under the Physician Fee Schedule and Anesthesia Services

(Rev. 2041, Issued: 08-31-10, Effective: 01-01-11, Implementation: 01-03-11)

The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the ZIP code. Though a number of additional services appear on the MPFS database, these payment jurisdiction rules apply only to those services actually paid under the MPFS and to anesthesia services. (For example, it does not apply to clinical lab, ambulance or drug claims.)

Effective for claims received on or after April 1, 2004, B/MACs must use the ZIP code of the location where the service was rendered to determine B/MAC jurisdiction over the claim and the correct payment locality. Effective for dates of service on or after October 1, 2007, except for services provided in POS “Home,” if they are not already doing so, B/MACs shall use the CMS *ZIP* code file along with the *ZIP* code submitted on the claim with the address that represents where the service was performed to determine the correct payment locality. (*See section 10.1.1B for instructions on processing services rendered in POS Home -12 and section 10.1.1.1 for instructions on when a 9-digit ZIP code is required.*)

When a physician, practitioner, or supplier furnishes physician fee schedule or anesthesia services in payment localities that span more than one B/MAC’s service area (e.g., provider has separate offices in multiple localities and/or multiple B/MACs), separate claims must be submitted to the appropriate area B/MACs for processing. For example, when a physician with an office in Illinois furnishes services outside the office setting (e.g., home, hospital, SNF visits) and that out-of-office service location is in another B/MAC’s service area (e.g., Indiana), the B/MAC which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the B/MAC with the correct physician fee schedule pricing data for the location where the service was furnished. In the majority of cases, the physician fee schedule or anesthesia services provided by physicians are within the same B/MAC jurisdiction that the physicians’ office(s) is/are located.

Although pricing rules for services paid under the MPFS remain in effect, effective for claims with dates of service on or after January 25, 2005, suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) must bill their local B/MAC for the technical component (TC) and professional component (PC) of diagnostic tests that are subject to the anti-markup payment limitation, regardless of the location where the service was furnished. Beginning in 2005, and in each subsequent calendar year (CY) thereafter, CMS will provide B/MACs with a national abstract file containing Healthcare Common Procedural Coding System (HCPCS) codes that are payable under the MPFS as anti-markup tests for the year. In addition, CMS will make quarterly updates to the abstract file to add and/or delete codes, as needed, in conjunction with the MFSDB quarterly updates. As with all other services payable under the MPFS, the ZIP code of the locality in which the service was furnished determines the payment amount. Refer to §30.2.9 of this Chapter for information on the anti-markup payment limitation as it applies to supplier billing requirements.

A. Multiple Offices

In states with multiple physician fee schedule pricing localities or where a provider has multiple offices located in two or more states, or there is more than one B/MAC servicing a particular state, physicians, suppliers and group practices with multiple offices in such areas must identify the specific location where office-based services were performed. This is to insure correct claim processing jurisdiction and/or correct pricing of MPFS and anesthesia services. The B/MAC must ensure that multiple office situations are cross-referenced within its system. If a physician/group with offices in more than one MPFS pricing locality or a multi-contractor state fails to specify the location where an office-based service was furnished, the B/MAC will return/reject the claim as unprocessable.

Physicians, suppliers, and group practices that furnish physician fee schedule services at more than one office/practice location may submit their claims through one office to the B/MAC for processing. However, the specific location where the services were furnished must be entered on the claim so the B/MAC has the ZIP code, can determine the correct claims processing jurisdiction, and can apply the correct physician fee schedule amount.

B. Service Provided at a Place of Service Other than Home-12 or Office-11

For claims submitted prior to April 1, 2004, in order to determine claims jurisdiction, Medicare approved charges, Medicare payment amounts, Medicare limiting charges and beneficiary liability, Part B fee-for-service claims for services furnished in other than in an office setting or a beneficiary's home must include information specifying where the service was provided.

Effective for claims received on or after April 1, 2004, claims for services furnished in all places of service other than a beneficiary's home must include information specifying where the service was provided. B/MACs must use the address on the beneficiary files when place of service (POS) is home - 12, or any other mechanism currently in place to determine pricing locality when POS is home - 12. B/MACs shall take this same action for any other POS codes they currently treat as POS home.

Effective for claims processed on or after October 5, 2009, for services rendered in POS home - 12, or for any other POS the contractor currently treats as POS home, when alerted by the shared system that a 9-digit ZIP code is required according to the CMS ZIP Code file, and a 9-digit ZIP code is not available on the beneficiary file, the contractor shall determine that ZIP code by using the United States Postal Service Web site. They shall use that ZIP code to determine the correct payment locality for the claim for pricing purposes.

B MACs processing these claims shall take necessary steps to ensure that the claims for services rendered in the physical location for which they are the MAC are priced and processed correctly applying appropriate edits as necessary.

Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the ANSI X12N 827 P electronic claim form, submission of the service facility location

(where the service was provided) will be required when the location of the health care service is different than that carried in Loop ID-2010AA (Billing Provider) and contractors shall use that ZIP code to determine correct payment locality.

Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the ANSI X12N 837 P electronic claim form, contractors shall return as unprocessable claims for services payable under the MPFS and anesthesia services when rendered in POS home (or any POS they consider home) if submitted without the service facility location.

Effective January 1, 2011 for claims processed on or after January 1, 2011 on paper claims submitted on the Form CMS-1500, submission of the ZIP code of where the service was provided will also be required for all POS code and contractors shall use that ZIP code to determine correct payment locality.

Contractors shall make no changes for claims submitted on the 4010A1 format as they pertain to POS Home and determining pricing locality.

Contractors shall require the submission of the 9-digit ZIP code when required per the CMS ZIP Code file.

C. Outside B/MAC Jurisdiction

If B/MACs receive claims outside of their jurisdiction, they must follow resolution procedures in accordance with the instructions in 10.1.9. If they receive a significant volume or experiences repeated incidences of misdirected Medicare Physician Fee Schedule or anesthesia services from a particular provider, an educational contact may be warranted.

D. HMO Claims

For services that HMOs are not required to furnish, B/MACs process claims for items or services provided to an HMO member over which they have jurisdiction in the same manner as they process other Part B claims for items or services provided by physicians or suppliers. Generally, the physician/supplier who provides in-plan services to its HMO members submits a bill directly to the HMO for payment and normally does not get involved in processing the claim. However, in some cases, claims for services to HMO members are also submitted to B/MACs, e.g., where claims are received from physicians for dialysis and related services provided through a related dialysis facility.

10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction

(Rev. 2041, Issued: 08-31-10, Effective: 01-01-11, Implementation: 01-03-11)

Provided below are separate instructions for processing electronic claims using the ANSI X12N 837 format and paper claims. See §30.2.9 and Chapter 12 for additional information on purchased tests.

A. *Instructions for the 4010/4010A1 Version of the ANSI X12N 837 P Electronic Claim Form*

Note that the following instructions do not apply to services rendered at POS home -12. For services rendered at POS home – 12, use the address on the beneficiary file *for the beneficiary's home* (or wherever else the beneficiary information is currently being stored) to determine pricing locality. (See §10.1.1 for changes to processing for services rendered at POS home – 12.)

Per the implementation guide of the 4010/4010A1 version of the ANSI X12N 837 P, it is acceptable for claims to contain the code for POS home and any number of additional POS codes. If different POS codes are used for services on the claim, a corresponding service facility location and address shall be entered for each service at the line level, if that location is different from the billing provider, pay-to-provider, or claim level service facility location. Pay the service based on the ZIP *code* of the service facility location, billing provider address, or pay-to provider address depending upon which information is provided.

Refer to the current implementation guide of the ANSI X12N 837 P to determine how information concerning where a service was rendered, the service facility location shall be entered on a claim. Per the documentation, though an address may not appear in the loop named “service facility address,” the information may still be available on the claim in a related loop.

EXAMPLE: On version 4010/4010A1 of the ANSI X12N 837 P electronic claim format, the Billing Provider loop 2010AA is required and therefore shall always be entered. If the Pay-To Provider Name and Address loop 2010AB is the same as the Billing Provider, only the Billing Provider will be entered. If no Pay-To Provider Name and Address is entered in loop 2010AB, and the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider, then only the Billing Provider will be entered. In this case, price the service based on the Billing Provider ZIP *code*.

EXCEPTION: For DMERC claims - Effective for claims received on or after 1/1/05, the Standard System shall not evaluate the 2010AA loop for a valid place of service. If there is no entry in the 2420C loop or the 2310D loop, the claim shall be returned as unprocessable.

- If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) will be entered. Price the service based on the ZIP *code* in Service Facility Location loop 2310D, unless the 2420C (line level) is also entered. In that case, price the service based on the ZIP *code* in the Service Facility Location loop 2420C (line level) for that line.

Make any necessary accommodations in claims processing systems to accept either the header level or line level information as appropriate and process the claims accordingly. No longer use the provider address on file when the POS is office to determine pricing locality and jurisdiction. Appropriate information from the claim shall always be used.

In the following situation, per the information in the 4010/4010A1 version of the ANSI X12N 837 P, the place where the service was rendered cannot be identified from the claim. In this situation, price all services on the claim based on the ZIP code in the Billing Provider loop. Continue to take this action until such time as the ASC documentation is revised to allow for identification of where the service was rendered to be identified from the claim.

If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D (claim level) or 2420C (line level) is the same as the Billing Provider or the Pay-To Provider, no entry is required per version 4010/4010A1 for Service Facility Location loop 2310D (claim level) or 2420C (line level).

When the same POS code and same service location address is applicable to each service line on the claim, the service facility location name and address shall be entered at the claim level loop 2310D.

In general, when the service facility location name and address is entered only at the claim level, use the ZIP *code* of that address to determine pricing locality for each of the services on the claim. When entered at the line level, the ZIP *code* for each line shall be used.

If the POS code is the same for all services, but the services were provided at different addresses, each service shall be submitted with line level information. This will provide a ZIP *code* to price each service on the claim.

B. *Instructions for the 5010 Version of the ANSI X12N 837 P Electronic Claim Form*

Per the implementation guide of the 5010 version of the ANSI X12N 837 P, a corresponding service facility location and address shall be entered for each service at the line level, if that location is different from the billing provider location. Pay the service based on the ZIP code of the address of where the service was performed based on the appropriate loop depending upon which information is provided.

C. Paper Claims Submitted on the Form CMS-1500

Note that *for claims processed on the Form CMS-1500 prior to January 1, 2011*, the following instructions do not apply to services rendered at POS home – 12 or any other places of service contractors consider to be home. (See §10.1.1.1)

It is acceptable for claims to contain POS home and an additional POS code. No service address for POS home needs to be entered for the service rendered at POS home in this situation as the address will be drawn from the beneficiary file (or wherever else the carrier is currently storing the beneficiary information) and the information on the claim will apply to the other POS.

Except for the situation described above, the provider shall submit separate claims for each POS. The specific location where the services were furnished shall be entered on the claim. Use the ZIP *code* of the address entered in Item 32 to price the claim. If multiple POS codes are

submitted on the same claim, treat *the claim* as unprocessable and follow the instructions in §80.3.1.

Use the following messages:

Remittance Advice – Adjustment Reason Code 16 – “Claim/service lacks information which is needed for adjudication. *At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.)*”

Remark Code –M77 – “Missing/incomplete/invalid place of service.”

MSN - 9.2 – “This item or service was denied because information required to make payment was missing.”

Effective January 1, 2011, for claims processed on or after January 1, 2011, submitted on the Form CMS-1500 paper claim, it will no longer be acceptable for the claim to have more than one POS. Separate claims must be submitted for each POS. Contractors shall treat claims submitted with more than one POS as unprocessable and follow the instructions in §80.3.2.1.1.

If the contractor receives a fee-for-service claim containing one or more services for which the MPFS payment locality is in another carrier’s jurisdiction, handle in accordance with the instructions in §10.1.9. If you receive a significant volume or experience repeated incidences of misdirected Medicare Physician Fee Schedule claims/services from a particular provider, an educational contact may be warranted. Handle misdirected claims/services for HMO enrollees in accordance with §10.1.1.C and D.

D. Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services When Rendered in a Payment Locality that Crosses ZIP Code Areas

Per the instructions above, Medicare *B/MACs* have been directed to determine the payment locality for services paid under the MPFS and anesthesia services by using the ZIP *code* on the claim of where the service was performed. It has come to the attention of CMS that some ZIP *codes* fall into more than one payment locality. The CMS ZIP Code file uses the convention of the United States Postal Service, which assigns these ZIP *codes* into dominant counties. In some cases, though the service may actually be rendered in one county, per the ZIP *code* it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount. Note that as the services on the Purchased Diagnostic Test Abstract file are payable under the MPFS, the 9-digit ZIP *code* requirements will also apply to those codes.

Effective for dates of service on or after October 1, 2007, CMS shall provide a list of the ZIP *codes* that cross localities as well as provide quarterly updates when necessary. The CMS ZIP Code file shall be revised to two files: one for 5-digit ZIP *codes* (ZIP5) and one for 9-digit ZIP *codes* (ZIP9). Providers performing services paid under the MPFS, anesthesia services, or any

other services as described above, in those ZIP codes that cross payment localities shall be required to submit the 9-digit ZIP codes on the claim for where the service was rendered. Claims for services payable under the MPFS and anesthesia services that are NOT performed in one of the ZIP code areas that cross localities may continue to be submitted with 5-digit ZIP codes. Claims for services other than those payable under the MPFS or anesthesia services may continue to be submitted with 5-digit ZIP codes.

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.

It should be noted that though some states consist of a single pricing locality, ZIP codes can overlap states thus necessitating the submission of the 9-digit ZIP code in order to allow the process to identify the correct pricing locality.

Claims received with a 5-digit ZIP code that is one of the ZIP codes that cross localities and therefore requires a 9-digit ZIP code to be processed shall be treated as unprocessable.

For claims received that require a 9-digit ZIP code with a 4-digit extension that does not match a 4-digit extension on file, manually verify the 4-digit extension to identify a potential coding error on the claim or a new 4-digit extension established by the U.S. Postal Service (USPS). ZIP code and county information may be found at the USPS Web site at <http://www.usps.com/>, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. The "Revision to Payment Policies Under the Physician Fee Schedule" that is published annually in the Federal Register, or any other available resource, may be used to determine the appropriate payment locality for the ZIP code with the new 4-digit extension. If this process does not validate the ZIP code, the claim shall be treated as unprocessable.

The following Remittance Advice and Remark Code messages shall be returned for the unprocessable claims:

Adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication. *At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.)*

Additional information is supplied using remittance advice remark codes whenever appropriate.

Remark Code MA 130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.

Remark Code MA114 – Missing/incomplete/*invalid* information on where the services were furnished.

Should a service be performed in a ZIP code area that does not require the submission of the 9-digit ZIP code, but the 4-digit extension has been included anyway, carriers shall price the claim using the carrier/locality on the ZIP5 file and ignore the 4-digit extension.

Effective for claims processed on or after July 6, 2009, the standard system shall make revisions to allow contractors to add valid 4-digit extensions not included on the current quarter's 9-digit ZIP Code file until they appear on a quarterly file.

Contractors shall reprocess claims brought to their attention if the next CMS quarterly file is received and the locality determination on a new 4-digit extension is different than that made manually by the contractor thus having inadvertently caused incorrect payment.

***E.* ZIP9 Code to Locality Record Layout**

Below is the ZIP9 Code to locality file layout. Information on the naming conventions, availability, how to download the ZIP5 and ZIP9 files, and the ZIP5 layout can be found in Pub. 100-04, Chapter 15, section 20.1.6.

ZIP9 Code to Locality Record Layout

(Effective for dates of service on or after October 1, 2007.)

<u>Field Name</u>	<u>Beg. Position</u>	<u>End Position</u>	<u>Length</u>	<u>Comments</u>
State	1	2	2	
ZIP Code	3	7	5	
Carrier	8	12	5	
Pricing Locality	13	14	2	
Rural Indicator	15	15	1	blank=urban, R=rural, B=super rural
Filler	16	20	5	
Plus Four Flag	21	21	1	0 = no +4 extension, 1 = +4 extension
Plus Four	22			

80.3.2.1.1 - Carrier Data Element Requirements

(Rev. 2041, Issued: 08-31-10, Effective: 01-01-11, Implementation: 01-03-11)

A - Required Data Element Requirements

1 - Paper Claims

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

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

Form CMS-1500 Items Affected by These Reporting Requirements:

Item 3 - Patient's Birth Date

Item 9b - Other Insured's Date of Birth

Item 11a - Insured's Date of Birth

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

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

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

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

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

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

- Item 24A. must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24A. will penetrate the dotted, vertical lines used to separate month, day, and year. Carrier claims processing systems will be able to process the claim if the date penetrates these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24A;
- Do not compress or change the font of the “year” item in item 24A. to keep the date within the confines of item 24A. If a continuous number is furnished in item 24A. with no spaces between month, day, and year, you will not need to compress the “year” item to remain within the confines of item 24A.;
- The “from” date in item 24A. must not run into the “to” date item, and the “to” date must not run into item 24B.;
- Dates reported in item 24A. must not be reported with a slash between month, day, and year; and
- If the provider of service or supplier decides to enter 8-digit dates for any of items 11b, 14, 16, 18, 19, or 24A. (excluding items 12 and 31), an 8-digit date must be furnished for all completed items. For instance, you cannot enter 8-digit dates for items 11b, 14, 16, 18, 19 (excluding items 12 or 31), and a 6-digit date for item 24A. The same applies to those who wish to submit 6-digit dates for any of these items.

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

2 - Electronic Claims

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

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

B - Required Data Element Requirements

The following Medicare-specific, return as unprocessable requirements in this section and the following two sections are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations implementing HIPAA require the use of National Provider Identifiers (NPIs) by covered health care providers and health plans.

Although not required by HIPAA, CMS is extending the requirement to include the NPI on electronic claims to paper claims submitted on the Form CMS-1500 (8/05). Carriers are referred to the Health Care Claims Professional 837 Implementation guide for requirements for professional claims subject to HIPAA, including the NPI reporting requirements.

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

Carriers shall return a claim as unprocessable:

1. If a claim lacks a valid Medicare Health Insurance Claim Number (HICN) in item 1a. or contains an invalid HICN in item 1a. (Remark code MA61.)
2. If a claim lacks a valid patient's last and first name as seen on the patient's Medicare card or contains an invalid patient's last and first name as seen on the patient's Medicare card. (Remark code MA36.)
3. If a claim does not indicate in item 11 whether or not a primary insurer to Medicare exists. (Remark code MA83 or MA92.)
4. If a claim lacks a valid patient or authorized person's signature in item 12 or contains an invalid patient or authorized person's signature in item 12. (See "Exceptions," bullet number one. Remark code MA75.)
5. If a claim lacks a valid "from" date of service in item 24A or contains an invalid "from" date of service in item 24A. (Remark code M52.)
6. If a claim lacks a valid place of service (POS) code in item 24B or contains an invalid POS code in item 24B, return the claim as unprocessable to the provider or supplier. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, if a claim contains more than one POS (other than Home – 12), for services paid under the MPFS and anesthesia services.

*Effective January 1, 2011, for claims processed on or after January 1, 2011 on the Form CMS-1500, if a claim contains more than one POS, including Home – 12, (or any POS contractors consider to be Home), for services paid under the MPFS and anesthesia services.
(Remark code M77.)*
7. If a claim lacks a valid procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D or contains an invalid or obsolete procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D. (Remark code M20 or M51.)

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

8. If a claim lacks a charge for each listed service. (Remark code M79.)
9. If a claim does not indicate at least 1 day or unit in item 24G (Remark Code M53.) (Note: To avoid returning the claim as “unprocessable” when the information in this item is missing, the carrier must program the system to automatically default to “1” unit).
10. If a claim lacks a signature from a provider of service or supplier, or their representative. (See “Exceptions,” bullet number one; Remark code MA70 for a missing provider representative signature, or code MA81 for a missing physician/supplier/practitioner signature.)
11. If a claim does not contain in item 33:
 - a. A billing name, address, ZIP Code, and telephone number of a provider of service or supplier. (Remark code N256 or N258.)

AND EITHER

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

OR

- c. A valid group PIN (or NPI when required) number or, for DMERC claims, a valid National Supplier Clearinghouse number (NPI in item 33a. of the Form CMS-1500 (8/05), when the NPI is required) for performing providers of service or suppliers who are members of a group practice. (Remark code N257)
12. If a claim does not contain in Item 33a., Form CMS 1500 (08-05), the NPI, when required, of the billing provider, supplier, or group. (Remark Code N257 or MA112.)
13. Effective May 23, 2008, if a claim contains a legacy provider identifier, e.g., PIN, UPIN, or National Supplier Clearinghouse number. (Remark Code N 257)

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

80.3.2.1.2 - Conditional Data Element Requirements for A/B MACs and DMEMACs

(Rev. 2041, Issued: 08-31-10, Effective: 01-01-11, Implementation: 01-03-11)

A - Universal Requirements

The following instruction describes “conditional” data element requirements, which are applicable to certain assigned A/B MAC claims. This instruction is minimal and does not include all “conditional” data element requirements, which are universal for processing claims. The CMS has specified which remark code(s) should be used when a claim fails a particular “return as unprocessable” edit and a remittance advice is used to return the claim. In addition to the specified remark code(s), A/B MACs must include Remark Code MA130 on returned claim(s). Reason code(s) must also be reported on every remittance advice used to return a claim or part of a claim as unprocessable.

Items from the Form CMS-1500 (hardcopy) have been provided. These items are referred to as fields in the instruction.

A/B MACs processing claims on the Form CMS-1500 must return a claim as unprocessable to the supplier/provider of service in the following circumstances:

- a. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified in Claim Specific Requirements) and his/her name and/or NPI is not present in item 17 or 17a or if the NPI is not entered in item 17b of the Form CMS-1500 (8/05). (Remark code N285 or N286 is used)
- b. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or NPI is required of the supervising physician is not entered in items 17 or 17a or if the NPI is not entered in item 17b of the Form CMS-1500 (8/05). (Remark code N269 or N270 is used.)
- c. For the technical component (TC) and professional component (PC) of diagnostic tests subject to the anti-markup payment limitation:
 1. If a “YES” or “NO” is not indicated in item 20 and no acquisition price is entered under the word “\$CHARGES.” A/B MACs shall assume the service is not subject to the anti-markup payment limitation. This claim shall not be returned as unprocessable for this reason only.
 2. If a “Yes” or “No” is not indicated in item 20 and an acquisition price is entered under the word “\$CHARGES.” (Remark Code MA110 is used.)
 3. If the “YES” box is checked in item 20 and a required acquisition price is not entered under the word “\$CHARGES.” (Remark code MA111 is used.)

4. If the “NO” box is checked in item 20 and an acquisition price is entered under the word “\$CHARGES.” (Remark code MA110 is used.)
5. If the “YES” box is checked in item 20 and the acquisition price is entered under “\$CHARGES”, but the performing physician or other supplier’s name, address, ZIP Code, and NPI is not entered into item 32a of the Form CMS-1500 (8/05) when billing for diagnostic services subject to the anti-markup payment limitation. (Remark code N294 is used.)

Entries 4 – 8 are effective for claims received on or after April 1, 2004:

4. On the Form CMS-1500, if the “YES” box is checked in Item 20, and more than one test is billed on the claim;
 5. On the Form CMS-1500, if both the TC and PC are billed on the same claim and the dates of service and places of service do not match;
 6. On the Form CMS-1500, if the “YES” box is checked in Item 20, both the TC and PC are submitted and the date of service and place of service codes do not match.
 7. On the ANSI X12N 837 electronic format, if there is an indication on the claim that a test is subject to the anti-markup payment limitation, more than one test is billed on the claim, and line level information for each total acquisition amount is not submitted for each test.
 8. On the Form CMS-1500 if the “YES” box is checked in Item 20 and on the ANSI X12N 837 electronic format if there is an indication on the claim that a test is subject to the anti-markup payment limitation, and the service is billed using a global code rather than having each component billed as a separate line item.
- d. If a provider of service or supplier is required to submit a diagnosis in item 21 and either an ICD-9CM code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. (Remark code M81 or M76 are used.)
 - e. *Available for future use.*
 - f. If a rendering physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner who is a sole practitioner or is a member of a group practice does not enter his/her NPI into item 24J of Form CMS-1500 (08-05) except for influenza virus and pneumococcal vaccine claims submitted on roster bills that do not require a rendering provider NPI. (Remark code N290 is used.)
 - g. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. (Remark code(s) MA64, MA88, MA89, or MA92 as appropriate for the missing piece(s) of data are used.)

- h. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act number, but a Payer or Plan identification number (use PlanID when effective) is not entered in field 11C, or the primary payer's program or plan name when a Payer or Plan ID (use PlanID when effective) does not exist. (Remark code MA92 or N245 is used.)
- i. If a HCPCS code modifier must be associated with a HCPCS procedure code or if the HCPCS code modifier is invalid or obsolete. (Remark code M20 if there is a modifier but no HCPCS.)
- j. If a date of service extends more than 1 day and a valid "to" date is not present in item 24A. (Remark code M59 is used.)
- k. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment. (Remark code M51 is used.)
- l. If the name, address, and ZIP Code of the facility where the service was furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office 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. (Remark code MA114 is used.)

Effective for claims with dates of service on or after October 1, 2007, the name, address, and 9-digit ZIP Code of the service location for services paid under the Medicare Physician Fee Schedule and anesthesia services, other than those furnished in place of service home – 12, and any other places of service A/B MACs treat as home, must be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1. (Remark code MA114 is used.)

Effective for claims with dates of service on or after October 1, 2007, for claims received that require a 9-digit ZIP Code with a 4 digit extension, a 4-digit extension that matches one of the ZIP9 file or a 4-digit extension that can be verified according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 must be entered on the claim. (Remark code MA114 is used.)

Effective January 1, 2011 for claims processed on or after January 1, 2011 on the Form CMS-1500, the name, address, and 5 or 9-digit ZIP code, as appropriate, of the location where the service was performed for services paid under the Medicare Physician Fee Schedule and anesthesia services, shall be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 for services provided in all places of service. (Remark code MA114 is used.)

Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the ANSI X12N 837 P electronic claim form for services payable under the MPFS and anesthesia services when rendered in POS home (or any POS they consider home) if submitted without the service facility location. (Remark code MA114 is used.)

- m. Effective for claims received on or after April 1, 2004, if more than one name, address, and ZIP Code is entered on the Form CMS-1500 (08-05) in item 32.
- n. If any of the modifiers PA, PB, or PC are incorrectly associated with a service which is other than a wrong surgery on a patient, surgery on the wrong body part, surgery on the wrong patient or a service related to one of these surgical errors. (Claim Adjustment Reason Code 4 is used.)

Medicare Claims Processing Manual

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

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

(Rev. 2041, Issued: 08-31-10, Effective: 01-01-11, Implementation: 01-03-11)

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.

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.

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

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

Item 24I - 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.