CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 317 **Date: OCTOBER 22, 2004**

CHANGE REQUEST 3431

SUBJECT: Clarification to Chapter 26 of the Internet Only Manual (IOM)

I. SUMMARY OF CHANGES: Chapter 26 is being revised to remove information that was added with no Change Request to justify this information being in chapter 26. Revisions are being made to add information that was in the Medicare Carriers Manual and not added to Pub. 100-04, Medicare Claims Processing Manual.

MANUALIZATION/CLARIFICATION – EFFECTIVE/IMPLEMENTATION DATES: Not Applicable.

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	26/10.2/Items 1-11-Patient and Insured Information
R	26/10.4/Items 14-35- Provider of Service or Supplier Information

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

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

10.2 - Items 1-11 - Patient and Insured Information

(Rev. 317, Issued 10-22-04, Effective/Implementation: N/A)

Item 1 - Show the type of health insurance coverage applicable to this claim by checking the appropriate box, e.g., if a Medicare claim is being filed, check the Medicare box.

Item 1a - Enter the patient's Medicare Health Insurance Claim Number (HICN) whether Medicare is the primary or secondary payer. This is a required field.

Item 2 - Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card. This is a required field.

Item 3 - Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

Item 4 - If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

Item 5 - Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

Item 6 - Check the appropriate box for patient's relationship to insured when item 4 is completed.

Item 7 - Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, *6,* and 11 are completed.

Item 8 - Check the appropriate box for the patient's marital status and whether employed or a student.

Item 9 - Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank. **This field may be used in the future for supplemental insurance plans.**

NOTE: Only Participating Physicians and Suppliers are to complete item 9 and its subdivisions and only when the Beneficiary wishes to assign his/her benefits under a MEDIGAP policy to the Participating Physician or Supplier.

Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer. (See chapter 28.)

Medigap - Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.

Item 9a - Enter the policy and/or group number of the Medigap insured *preceded* by **MEDIGAP, MG, or MGAP**.

NOTE: Item 9d must be completed if the provider enters a policy and/or group number in item 9a.

Item 9b - Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.

Item 9c - Leave blank if a Medigap PayerID is entered in item 9d. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card. For example:

1257 Anywhere Street
Baltimore, MD 21204

is shown as "1257 Anywhere St. MD 21204."

Item 9d - Enter the 9-digit PAYERID number of the Medigap insurer. If no PAYERID number exists, then enter the Medigap insurance program or plan name.

If the beneficiary wants Medicare payment data forwarded to a Medigap insurer under a mandated Medigap transfer, the participating provider of service or supplier must accurately complete all of the information in items 9, 9a, 9b, and 9d. Otherwise, the Medicare carrier cannot forward the claim information to the Medigap insurer.

Items 10a through 10c - Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in

item 24. Enter the State postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

Item 10d - Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.

Item 11 - THIS ITEM MUST BE COMPLETED, IT IS A REQUIRED FIELD. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed.

NOTE: Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11.

If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.

If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

If a lab has collected previously and retained MSP information for a beneficiary, the lab may use that information for billing purposes of the non-face-to-face lab service. If the lab has no MSP information for the beneficiary, the lab will enter the word "None" in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

Insurance Primary to Medicare - Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
    - Working Aged;
    - Disability (Large Group Health Plan); and
    - End Stage Renal Disease;
- No Fault and/or Other Liability; and
- Work-Related Illness/Injury:
    - Workers' Compensation;

- Black Lung; and
- Veterans Benefits.

NOTE: For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form. *(See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3.)*

10.3 - Items 11a - 13 - Patient and Insured Information

(Rev. 317, Issued 10-22-04, Effective/Implementation: N/A)

Item 11a - Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

Item 11b - Enter employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word "RETIRED."

Item 11c - Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in *item* 11.

Item 11d - Leave blank. Not required by Medicare.

Item 12 - The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file in accordance with Chapter 1, “General Billing Requirements.” If the patient is physically or mentally unable to sign, a representative specified in Chapter 1, "General Billing Requirements” may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by “by” the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless patient or the patient's representative revokes this arrangement.

NOTE: This can be "Signature on File" and/or a computer generated signature.

The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

Signature by Mark (X) - When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

Item 13 - The signature in this item authorizes payment of mandated Medigap benefits to the participating physician or supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating provider of service/supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

NOTE: This can be "Signature on File" signature and/or a computer generated signature.

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

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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 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.

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 nonphysician 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 and Unique Physician Identification Number (UPIN). This includes parenteral and enteral nutrition, immunosuppressive drug claims, and the following:

- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services; and
- Durable medical equipment.

Claims for other ordered/referred services not included in the preceding list shall also show the ordering/referring physician's name and UPIN (the NPI will be used when implemented). For example, a surgeon shall complete items 17 and 17a when a physician refers the patient. When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests), the performing physician's name and assigned UPIN (the NPI will be used when implemented) appear in items 17 and 17a.

When a service is incident to the service of a physician or non-physician practitioner, the name and assigned UPIN (the NPI shall be used when implemented) of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in items 17 and 17a.

All physicians who order or refer Medicare beneficiaries or services *shall* obtain a UPIN (the NPI will be used when implemented) even though they may never bill Medicare directly. A physician who has not been assigned a UPIN *shall* contact the Medicare carrier.

When a physician extender or other limited licensed practitioner refers a patient for consultative service, the name and UPIN (the NPI will be used when implemented) of the physician supervising the limited licensed practitioner *shall* appear in items 17 and 17a.

When a patient is referred to a physician who also orders and performs a diagnostic service, a separate claim form is required for the diagnostic service.

Enter the original ordering/referring physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the first claim form.

Enter the ordering (performing) physician's name and UPIN (the NPI will be used when implemented) in items 17 and 17a of the second claim form (the claim for reimbursement for the diagnostic service).

Surrogate UPINs - If the ordering/referring physician has not been assigned a UPIN (the NPI will be used when implemented), one of the surrogate UPINs listed below *shall* be used in item 17a. The surrogate UPIN used depends on the circumstances and is used only until the physician is assigned a UPIN. Enter the physician's name in item 17 and the surrogate UPIN in item 17a. All surrogate UPINs, with the exception of retired physicians (RET00000), are temporary and may be used only until a UPIN is assigned. The *carrier shall* monitor claims with surrogate UPINs.

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.

Item 17a - Enter the CMS assigned UPIN (the NPI will be used when implemented) of the referring/ordering physician listed in item 17.

When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 *shall* be used for each ordering/referring physician.

Contractors use the following surrogate UPINs for physicians who have not been assigned individual UPINs. Claims received with surrogate numbers will be tracked and possibly audited.

- Residents who are issued a UPIN in conjunction with activities outside of their residency status use that UPIN. For interns and residents without UPINs, use the 8-character surrogate UPIN RES00000;

- Retired physicians who were not issued a UPIN may use the surrogate RET00000;

- Physicians serving in the Department of Veterans Affairs or the U.S. Armed Services may use VAD00000;

- Physicians serving in the Public Health or Indian Health Services may use PHS00000;

- When the ordering/referring physician has not been assigned a UPIN and does not meet the criteria for using one of the surrogate UPINs, the biller may use the surrogate UPIN "OTH00000" until an individual UPIN is assigned.

- *The UPIN must be entered in item 17a for hepatitis B claims.*

  NOTE: This field is required when a service was ordered or referred by a physician.

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

Item 19 – *Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the UPIN (NPI when it becomes effective) of his/her attending physician when an independent physical or occupational therapist submits claims or a physician providing routine foot care submits claims. For physical or occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file.*

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, are 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 a*n* 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 participating provider. In this case, no payment may be made on the claim.

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 pin (or UPIN when effective) of the physician who is performing a purchased interpretation of a diagnostic test. (See Pub. 100-04, chapter 1, section 30.2.9.1 for additional information.)

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.)

Item 20 - Complete this item when billing for diagnostic tests subject to purchase price limitations. Enter the purchase price under charges if the "yes" block is checked. A "yes" check indicates that an entity other than the entity billing for the service performed the diagnostic test. A "no" check indicates "no purchased tests are included on the claim." When "yes" is annotated, item 32 *shall* be completed. When billing for multiple purchased diagnostic tests, *each test shall be submitted on a separate claim Form CMS-1500*. Multiple purchased tests may be submitted on the ASC X12 837 electronic format as long as appropriate line level information is submitted when services are rendered at different service facility locations. See chapter 1.

NOTE: This is a required field when billing for diagnostic tests subject to purchase price limitations.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity *for the date of service*. Enter up to four codes in priority order (primary, secondary condition). An independent laboratory *shall* enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for nonphysician specialties *shall* be submitted on an attachment.

Item 22 - Leave blank. Not required by Medicare.

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

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

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

When a physician provides services to a beneficiary residing in a SNF and the services were rendered to a SNF beneficiary outside of the SNF, the physician *shall* enter the Medicare facility provider number of the SNF in item 23.

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

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 one 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.

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

Return as unprocessable if an "unlisted procedure code" or a*n* (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.

Suppliers furnish the units of oxygen contents except for concentrators and initial rental claims for gas and liquid oxygen systems. Rounding of oxygen contents is as follows:

For stationary gas system rentals, suppliers indicate oxygen contents in unit multiples of 50 cubic feet in item 24g, rounded to the nearest increment of 50. For example, if 73 cubic feet of oxygen were delivered during the rental month, the unit entry "01" indicating the nearest 50 cubic foot increment is entered in item 24g.

For stationary liquid systems, units of contents *shall* be specified in multiples of 10 pounds of liquid contents delivered, rounded to the nearest 10-pound increment. For example, if 63 pounds of liquid oxygen were delivered during the applicable rental month billed, the unit entry "06" is entered in item 24g.

For units of portable contents only (i.e., no stationary gas or liquid system used), round to the nearest *5* feet or 1 liquid pound, respectively.

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

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

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

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

Item 24K - Enter the PIN (the NPI will be used when implemented) of the performing provider of service/supplier if the provider is a member of a group practice. When several different providers of service or suppliers within a group are billing on the same Form CMS-1500, show the individual PIN (or NPI when implemented) in the corresponding line item. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN (or NPI when implemented) of the supervisor in *item* 24k.

Item 25 - Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number. The participating provider of service or supplier Federal Tax ID number is required for a mandated Medigap transfer.

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, the name, address, and zip code of the service location for all services other than those furnished in place of service home – 12.

Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and zip code may be entered in the block. If additional entries are needed, separate claim forms *shall* be submitted.

Providers of service (namely physicians) *shall* identify the supplier's name, address, ZIP code and PIN when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted *Form* CMS-1490S, before the claim is

entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name address, or PIN of the location where the order was accepted must be entered (DMERC only).

This field is required. When more than one supplier is used, a separate Form CMS-1500 should be used to bill for each supplier.

This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If a QB or QU modifier is billed, indicating the service was rendered in a Health Professional Shortage Area (HPSA), the physical location where the service was rendered *shall* be entered if other than home.

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

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

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

Enter the *PIN (or NPI when implemented)*, for the performing provider of service/supplier who is **not** a member of a group practice.

Enter the group PIN *(or NPI when implemented)*, for the performing provider of service/supplier who is a member of a group practice.

Suppliers billing the DMERC will use the National Supplier Clearinghouse (NSC) number in this *item*.

Enter the group UPIN, including the 2-digit location identifier, for the performing practitioner/supplier who is a member of a group practice.