CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2842	**Date: December 27, 2013**
	Change Request 8509

SUBJECT: Form CMS-1500 Instructions: Revised for Form Version 02/12

I. SUMMARY OF CHANGES: This Change Request revises the current Form CMS-1500 instructions to reflect the revised 1500 form, version 02/12.

EFFECTIVE DATE: January 6, 2014
IMPLEMENTATION DATE: January 6, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	26/10/Health Insurance Claim Form CMS-1500
R	26/10/10.2/Items 1-11 Patient and Insured Information
R	26/10/10.3/Items11a-13 Patient and Insured Information
R	26/10/10.4/Items 14-33 Provider of Service or Supplier Information

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged 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.*

Business Requirements

Pub. 100-04	Transmittal: 2842	Date: December 27, 2013	Change Request: 8509

SUBJECT: Form CMS-1500 Instructions: Revised for Form Version 02/12

EFFECTIVE DATE: January 6, 2014
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I. GENERAL INFORMATION

A. Background: The National Uniform Claim Comittee (NUCC) recently revised Form CMS-1500. On June 10, 2013, the White House Office of Management and Budget (OMB) approved the revised form, 02/12. This form will replace the current Form CMS-1500, 08/05, effective with claims received on and after April 1, 2014. Medicare will begin accepting claims on the revised form, 02/12, on January 6, 2014. However, Medicare will continue to accept claims on the old form, 08/05, through March 31, 2014. On April 1, 2014, Medicare will accept paper claims on only the revised Form 1500, 02/12. On and after April 1, 2014, Medicare will no longer accept claims on the old Form CMS-1500, 08/05.

The revised form has a number of changes. Those most notable for Medicare are new indicators to differentiate between ICD-9 and ICD-10 codes on a claim, and qualifiers to identify whether certain providers are being identified as having performed an ordering, referring, or supervising role in the furnishing of the service. In addition, the revised form uses letters, instead of numbers, as diagnosis code pointers, and expands the number of possible diagnosis codes on a claim to 12.

The purpose of these instructions is to instruct the contractors as to the way in which providers are to submit data on the revised form. To the extent possible, Medicare has kept the instructions the same as they were for 08/05, changing the instructions only as applicable to Medicare claims and where changes reflected in the revised form prevent continuing to include certain data. These instructions will also form the basis of an MLN article for providers.

In addition, this CR provides direction to the contractors as to handling the data coming in on the revised form where the actions to take may be unclear. As previously noted, these instructions duplicate the previous instructions as much as possible and change only where needed.

B. Policy: The Administrative Simplification Compliance Act (ASCA) requires Medicare claims to be sent electronically unless certain exceptions are met. Those providers meeting these exceptions are permitted to submit their claims to Medicare on paper. Medicare requires that the paper format for professional and supplier paper claims be the Form CMS-1500. Medicare therefore supports the implementation of this form, including OMB-approved revisions, for use by its professional providers and suppliers meeting an ASCA exception. More information about ASCA exceptions can be found in the Pub. 100-04, Medicare Claim Processing Manual, Chapter 24.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility			
		A/B MAC	DME	Shared-System Maintainers	Other

		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
8509.1	Contractors shall ensure that their providers using the 1500 claim form adhere to the instructions in Pub. 100-04, Medicare Claims Processing Manual, chapter 26 and revised in this CR.		X		X					RRB-SMAC
8509.2	Contractors shall ensure that claims submitted on Form 1500 (02/12) contain a valid qualifier for item 17 when item 17 has been completed. The choices for qualifier are DK, DN, and DQ.		X							RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
8509.3	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites 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 the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.		X		X	

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

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

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

V. CONTACTS

Pre-Implementation Contact(s): Claudette Sikora, 410-786-5618 or claudette.sikora@cms.hhs.gov , Matthew Klischer, 410-786-7488 or matthew.klischer@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do 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 26 - Completing and Processing Form CMS-1500 Data Set

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(Rev.2842, Issued: 12-27-13)

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10 - Health Insurance Claim Form CMS-1500

(Rev. .2842, Issued: 12-27-13, Effective: 01-06-14, Implementation: 01-06-14)

The Administrative Simplification Compliance Act (ASCA) requires that Medicare claims be sent electronically unless certain exceptions are met. Providers meeting an ASCA exception may send their claims to Medicare on a paper claim form. (For more information regarding ASCA exceptions, refer to Chapter 24.)

Providers sending professional and supplier claims to Medicare on paper must use Form CMS-1500 in a valid version. This form is maintained by the National Uniform Claim Committee (NUCC), an industry organization in which CMS participates. Any new version of the form must be approved by the White House Office of Management and Budget (OMB) before it can be used for submitting Medicare claims. When the NUCC changes the form, CMS coordinates its review, any changes, and approval with the OMB.

The NUCC has recently changed the Form CMS-1500, and the revised form received OMB approval on June 10, 2013. The revised form is version 02/12, OMB control number 0938-1197.

The revised form will replace the previous version of the form 08/05, OMB control number 0938-0999.

Throughout this chapter, the terms, "Form CMS-1500," "Form 1500," and "CMS-1500 claim form" may be used to describe this form depending upon the context and version. The term, "CMS-1500 claim form" refers to the form generically, independent of a given version.

Medicare will conduct a dual-use period during which providers can send Medicare claims on either the old or the revised forms. When the dual-use period is over, Medicare will accept paper claims on only the revised Form 1500, version 02/12.

For the implementation and dual-use dates, contractors shall consult the appropriate implementation change requests for the revised Form 1500 . Providers and other interested parties may obtain the implementation dates on the CMS web site @ www.cms.gov.

Reminder: Regardless of the paper claim form version in effect: ***Providers cannot submit ICD-10 codes for claims with dates of service prior to October 1, 2014.***

Medicare A/B MACS (B), DME MACS, physicians, and suppliers are responsible for purchasing their own CMS-1500 *claim* forms. Forms can be obtained from printers or printed in-house as long as they *follow the specifications developed by the NUCC*. Photocopies of the CMS-1500 *claim form* are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the CMS-1500 *claim form* for processing. To purchase forms from the U.S. Government Printing Office, call (202) 512-1800.

The following instructions are required for a Medicare claim. *They apply to both the 08/05 and 02/12 versions of the form except where noted.* A/B MACs *(B) and DME MACs* should provide information on completing the CMS-1500 *claim form* to all physicians and suppliers in their area at least once a year.

These instructions represent the minimum requirements for using this form to submit a Medicare claim. However, depending on a given Medicare policy, there may be other data that should also be included on the CMS-1500 claim form; if so, these additional requirements are addressed in the instructions you received for such policies (e.g., other chapters of this manual).

Providers may use these instructions to complete this form. The CMS-1500 *claim form* has space for physicians and suppliers to provide information on other health insurance. This information can be used by A/B MACs *(B)* to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment, or whether there is another insurer to which Medicare can forward billing and payment

data following adjudication if the provider is a physician or supplier that participates in Medicare. (See Pub. 100-05, Medicare Secondary Payer Manual, chapter 3, and chapter 28 of this manual).

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

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

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

10.2 - Items 1-11 - Patient and Insured Information

(Rev. .2842, Issued: 12-27-13, Effective: 01-06-14, Implementation: 01-06-14)

Item 1 - Shows the type of health insurance coverage applicable to this claim by the appropriately checked box; 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 – *Form version 08/05:* Check the appropriate box for the patient's marital status and whether employed or a student.
Form version 02/12: Leave blank.

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 *b*eneficiary 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 *A/B MAC (B) or DME MAC* 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, even when the provider enters a policy and/or group number in item 9a.

Item 9b – *Form version 08/05*: Enter the Medigap insured's 8-digit birth date (MM | DD | CCYY) and sex.
Form version 02/12: Leave blank.

Item 9c - Leave blank if *item 9d is completed*. 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 *Coordination of Benefits Agreement (COBA) Medigap-based Identifier (ID). Refer to chapter 28, section 70.6.4, of this manual for more information.*

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 *Medicare Secondary Payer (*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, 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 *MSP* 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. .2842, Issued: 12-27-13, Effective: 01-06-14, Implementation: 01-06-14)

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

Item 11b – *Form version 08/05:* 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."
Form version 02/12: provide this information to the right of the vertical dotted line.

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, 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 the 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 patient's signature or the statement "signature on file" in this item authorizes payment of medical benefits to the physician or supplier. The patient or his/her authorized representative signs this item or the signature must be on file separately with the provider as an authorization. However, note that when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, a patient's signature or a "signature on file" is not required in order for Medicare payment to be made directly to the physician or supplier.

The presence of or lack of a signature or "signature on file" in this field will be indicated as such to any downstream coordination of benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that providers accurately address this field as it may affect supplemental payments to providers and/or their patients.

In addition, 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

(Rev. .2842, Issued: 12-27-13, Effective: 01-06-14, Implementation: 01-06-14)

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

Item 14 - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of current illness, injury, or pregnancy. For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.
Additional information for form version 02/12: Although this version of the form includes space for a qualifier, Medicare does not use this information; do not enter a qualifier in item 14.

Item 15 - Leave blank.

Item 16 - If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date when patient is unable to work. An entry in this field may indicate employment related insurance coverage.

Item 17 - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician . All physicians who order services or refer Medicare beneficiaries must report this data. *Similarly, if Medicare policy requires you to report a supervising physician, enter this information in item 17.* When a claim involves multiple referring, ordering, *or supervising* physicians, *use* a separate CMS-1500 *claim form* for each ordering, referring, *or supervising* physician.

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

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

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

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

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

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;

2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;

3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;

4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or

5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub. 100-02, Medicare Benefit Policy Manual, chapter 15 for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner;

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

Item 17a – Leave blank.

Item 17b – Enter the NPI of the referring, ordering, *or supervising* physician *or non-physician practitioner* listed in item 17. All physicians *and non-physician practitioners* who order services or refer Medicare beneficiaries must report this data.

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

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

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

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

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

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* 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," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively, for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

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

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

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

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

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

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

Enter demonstration ID number “56” for all national Laboratory Affordable Care Act Section 113 Demonstration Claims.

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

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

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

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

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

NOTE: This is a required field when billing for diagnostic tests subject to the anti-markup payment limitation.

Item 21 - Enter the patient's diagnosis/condition. With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use *diagnosis codes* to the highest level of specificity for the date of service. Enter *the* diagnoses in priority order. All narrative diagnoses for nonphysician specialties shall be submitted on an attachment.

Reminder: Do not report ICD-10-CM codes for claims with dates of service prior to October 1, 2014, on either the old or revised version of the CMS-1500 claim form.

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

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

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

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

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

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

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

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

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

Item 22 - Leave blank. Not required by Medicare.

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

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

For physicians performing care plan oversight services, enter the NPI of the home health agency (HHA) or hospice when CPT code G0181 (HH) or G0182 (Hospice) is billed.

Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures.

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

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

Item 24 - The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11 digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six

bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g., UN2 or F2999999).

Item 24A - Enter a 6-digit or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field. Return as unprocessable if a date of service extends more than 1 day, and a valid "to" date is not present.

Item 24B - Enter the appropriate place of service code(s) from the list provided in section 10.5. Identify the setting, using a place of service code, for each item used or service performed. This is a required field.

NOTE: When a service is rendered to a patient who is a registered inpatient or an outpatient of a hospital, use the inpatient hospital POS code 21 or outpatient hospital POS code 22, respectively, as discussed in section 10.5 of this chapter.

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

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

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

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

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

When using form version 08/05, this reference will be either a 1, or a 2, or a 3, or a 4.
When using form version 02/12, the reference to supply in 24E will be a letter from A-L. Otherwise, the instructions above apply.

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

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

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

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

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

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

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

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

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

Item 24I - 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 – For services payable under the physician fee schedule and anesthesia services, enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, only one name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted. Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes.

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

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The *A/B MAC (B)* processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DME MAC only). This field is required. When more than one supplier is

used, a separate CMS-1500 *claim form* shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

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

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

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

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

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

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

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