Medicare
Carriers Manual
Part 4 - Professional Relations

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

Transmittal 25 **Date: NOVEMBER 1, 2001**

CHANGE REQUEST 1910

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2010.2 (Cont) – 2010.2 (Cont)	2-17 – 2-18 (2pp.)	2-17 – 2-18 (2pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: April 1, 2002*
IMPLEMENTATION DATE: April 1, 2002

Section 2010.2, Item 19, is revised to delete the hospice attending physician attestation statement requirement. The attestation statement has been replaced by a new GV modifier.

These instructions should be implemented within your current operating budget.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

Item 18. Enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) 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 8-digit (MM | DD | CCYY) date patient was last seen and the NPI of his/her attending physician when an independent physical or occupational therapist or physician providing routine foot care submits claims. For physical and occupational therapists, entering this information certifies that the required physician certification (or recertification) is being kept on file (See §2206.1, Part 3 of MCM).

Enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) x-ray date for chiropractor services. By entering an x-ray date, and the initiation date for course of chiropractic treatment in item 14, you are certifying that all the relevant information requirements (including level of subluxation) of the §2251, Part 3 of MCM and §4118, Part 3 of MCM 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 NOC code if one can be given within the confines of this box. Otherwise an attachment must 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 §2051.1, Part 3 of MCM and §2070.1, Part 3 of MCM 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 either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

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 that "no purchased tests are included on the claim." When "yes" is annotated, item 32 must be completed. When billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form.

Item 21. Enter the patient's diagnosis/condition. All physician specialties must use an ICD-9-CM code number and code to the highest level of specificity. Enter up to 4 codes in priority order (primary, secondary condition). An independent laboratory must enter a diagnosis only for limited coverage procedures.

All narrative diagnoses for non-physician specialties must be submitted on an attachment.

Item 22. Leave blank. Not required by Medicare.

Item 23. Enter the professional review organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

Enter the Investigational Device Exemption (IDE) number when an investigational device is used in an FDA-approved clinical trial.

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 99375 or 99376 or HCPCS code G0064, G0065, or G0066 is billed.

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

Item 24a. Enter either a 6-digit (MM | DD | YY) 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.

Item 24b. Enter the appropriate place of service code(s) from the list provided in §2010.3. Identify the location, using a place of service code, for each item used or service performed.

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 Health Care Procedure Coding System (HCPCS). When applicable, show HCPCS modifiers with the HCPCS code.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a 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 must be submitted with the claim.

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.

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

Item 24f. Enter the charge for each listed service.