

SECTION 7 - MEDICARE PART B

<u>TITLE</u>	<u>PAGE</u>
FILE LAYOUT GRAPHIC ILLUSTRATION	7.2
RECORD OCCURRENCE CHART	7.3
NSF FIELD REQUIREMENTS	7.4
NSF FIELD DEFINITIONS	7.7
GENERAL INFORMATION	7.24
BENEFICIARY SIGNATURE REQUIREMENTS	7.24
DIAGNOSIS CODE REQUIREMENTS	7.25
EMC BILLING LIMITATIONS	7.26
CLAIMS REQUIRING SUPPORTING DOCUMENTATION	7.26
SPECIFIC CLAIM TYPE REQUIREMENTS	7.26
AMBULANCE CLAIMS	7.26
ANESTHESIA CLAIMS	7.26
CARE PLAN OVERSIGHT	7.26
CHIROPRACTIC CLAIMS	7.26
CLINICAL PATHOLOGY CONSULTATIONS	7.26
INDEPENDENT PHYSICAL OR OCCUPATIONAL THERAPIST, OR PHYSICIAN PROVIDING ROUTINE FOOT CARE	7.27
INITIAL EPO CLAIMS	7.27
MEDICARE PRIMARY - NO SECONDARY	7.27
MEDICARE PRIMARY - MEDIGAP SECONDARY	7.28
MEDICARE PRIMARY - OTHER SECONDARY	7.28
MEDICARE PRIMARY - MEDICAID SECONDARY	7.29
MEDICARE PRIMARY - BLUE SHIELD SECONDARY	7.29
MEDICARE SECONDARY	7.29
MODIFIER 20 - MICROSURGERY	7.30
MODIFIER 22 - UNUSUAL SERVICES	7.30
MODIFIER 52 - REDUCED SURGERY	7.30
MODIFIER 99 - MULTIPLE MODIFIERS	7.30
MODIFIERS NOT FOR EMC USE	7.30
NOT OTHERWISE CLASSIFIED (NOC) PROCEDURE CODES	7.31
PACEMAKER SYSTEMS	7.31
POSTOPERATIVE MANAGEMENT ONLY	7.31
PURCHASE DIAGNOSTIC TESTS	7.31
REFERRAL LAB BILLING	7.32
MEDICARE PART B TEST DATA	7.33
MEDICARE PART B - ANSI IMPLEMENTATION GUIDELINES	7.34

RECORD OCCURRENCE CHART

10/01/97

AA0 & ZA0	A submission may contain multiple files. The total record count for the file cannot exceed 9,999,999 records.
BA0 & YA0	A file may contain up to 9,999 batches. All batches within the file must be for the same payor.
CA0 & XA0	A batch may contain 9,999,999 claims. All claims within the batch must be for the same provider number.
DA0	There must be one DA0 record per claim and there cannot be more than three DA0 records per claim. Medicare Part B does not recognize the third DA0 record.
DA1, DA2, DA3	None to three occurrences per claim.
EA0	One per claim is required.
EA1	None to one per claim.
FA0	One per claim is required. Cannot exceed 32 per claim.
FB0, GA0, GC0, HA0	None to 32 per claim.
CA1,EA2, FB1, FB2, FB3, FE0, FD0, GD0, GD1, GE0, GP0, GU0, GX0, GX1, GX2	These records are not utilized/recognized by Medicare Part B.

NSF FIELD REQUIREMENTS - MEDICARE B

FIELD	RECORDS														
	A A 0	B A 0	C A 0	D A 0	D A 1	E A 0	E A 1	F A 0	F B 0	G A 0	G C 0	H A 0	X A 0	Y A 0	Z A 0
01.0	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
02.0	R			R	R			R	R	R	R	R			R
03.0		R	C											R	
04.0	R		R	R	C	R	C								R
05.0	R	R	R	R		R		R	C		R	C		R	
06.0				R	C		C	C			R				R
07.0				R	C			R							R
08.0					C		C			R					R
09.0		R	R	C			C	R		R				R	R
10.0							C	C		R			R	R	
11.0			R		C			C	C	R				R	
12.0										R			R		
13.0			R			R		R		R					
14.0			R	C	C			R		R					
15.0	R		R	R						R					
16.0				R			C								
17.0	R			R											
18.0	R			R				R		R					
19.0	R							C		R			R		
20.0	R					C				C			R		
21.0	R									C					
22.0	R														
23.0			R					C							
24.0						C		C		C					

NSF FIELD REQUIREMENTS - MEDICARE B

FIELD	RECORDS														
	A A 0	B A 0	C A 0	D A 0	D A 1	E A 0	E A 1	F A 0	F B 0	G A 0	G C 0	H A 0	X A 0	Y A 0	Z A 0
25.0															
26.0								C							
27.0				C											
28.0															
29.0															
30.0						C									
31.0						C									
32.0						C									
33.0						C									
34.0						C		C							
35.0						C									
36.0						R									
37.0						R									
38.0															
39.0						C									
40.0								C							
41.0								C							
42.0								C							
43.0						C		C							
44.0								C							
45.0								C							
46.0								C							
47.0								C							
48.0						C									
49.0															

NSF FIELD REQUIREMENTS - MEDICARE B

FIELD	RECORDS														
	A A 0	B A 0	C A 0	D A 0	D A 1	E A 0	E A 1	F A 0	F B 0	G A 0	G C 0	H A 0	X A 0	Y A 0	Z A 0
50.0						C									
51.0															
52.0															
53.0						C									
54.0						C									
55.0 THRU 95.0															

R - Indicates the submission of data in this field is required.

C - Indicates the submission of data in this field is conditional, i.e., required when certain conditions are met.

NSF FIELD DEFINITIONS

This section is designed to provide field definitions for Medicare Part B claims processing. Only the R (Required) and C (Conditional) fields that have limitations/instructions other than those defined in the HCFA National Standard Format Specifications are defined here. If a field is identified as required and there is no definition in this section, refer the HCFA NSF specifications for a definition or valid value.

AA0-02.0 SUBMITTER IDENTIFIER

Submitter ID's are assigned by Texas Health Information Network (THIN). THIN will only use the first six positions. Must be identical to the submitter identifier in file trailer (ZA0-02.0) and must match the Login ID used to access rEDI-link Blue. Contact the EDI Helpline for the correct submitter identification number.

FILE REJECT - MESSAGE 121

AA0-05.0 SUBMISSION NUMBER

Must be six digit alpha-numeric value for each submission. No embedded blanks or special characters are allowed. Duplicate file IDs for a submitter (AA0-02.0) submitted within six months will be rejected.

FILE REJECT - MESSAGE 107, 112

AA0-15.0 CREATION DATE

Must be a valid date in CCYYMMDD format.

FILE REJECT - MESSAGE 105

AA0-17.0 RECEIVER IDENTIFICATION

Must equal receiver identification in file trailer (ZA0-04.0). Valid Medicare Part B values are:

- 00900 - Texas
- 00901 - Maryland
- 00902 - Delaware (previously 00570)
- 00903 - DC Metropolitan Area (previously 00580)

FILE REJECT - MESSAGE 124

AA0-18.0 RECEIVER TYPE CODE

Must equal "C" for Medicare Part B.

FILE REJECT - MESSAGE 123

AA0-19.0 VERSION CODE - NATIONAL

Current version code is 00301. We will continue to accept version 001.04 and 002.00 until further notice.

FILE REJECT - MESSAGE 113

AA0-20.0 VERSION CODE - LOCAL

Current version code is 00301. We will continue to accept version 001.04 and 002.00 until further notice. Must match National Version Code (AA0-19.0).

AA0-21.0 TEST/PRODUCTION INDICATOR

All files are handled as production unless:

- This field contains “TEST”,
- The provider has not completed and returned all the necessary EDI Enrollment and Agreement forms.

AA0-22.0 PASSWORD

Required for all submissions. The password is assigned by THIN. Must be six digit alpha-numeric. Contact the EDI Helpline for verification of the password.

FILE REJECT - MESSAGE 122

BA0-03.0 BATCH TYPE

Only batch type “100”, is valid for Medicare Part B.

BATCH REJECT - MESSAGE 201

BA0-05.0 BATCH IDENTIFICATION

Must be six digit alpha-numeric value for each batch ID. No embedded blanks or special characters are allowed. Duplicate batch IDs for a billing provider (BA0-09.0) submitted within six months will be rejected.

BATCH REJECT - MESSAGE 205, 212

BA0-09.0 PROVIDER MEDICARE NUMBER

Enter the Medicare PIN or Group Number. Must equal EMC Provider ID (BA0-02.0).

BATCH REJECT - MESSAGE 240

CA0-03.0 PATIENT CONTROL NUMBER

Medicare Part B will carry the **first fourteen** positions of this field into the claims processing system and return it on the Medicare remittance notices.

CA0-04.0 PATIENT LAST NAME

Enter the patients’ last name. First position must be A - Z. May contain a hyphen (-) or a blank (.). No other special characters are allowed. Must be at least two characters.

CLAIM INFORMATIONAL - MESSAGE 6EA

CLAIM REJECT - MESSAGE 6EP

CA0-05.0 PATIENT FIRST NAME

Enter the patients' last name. First position must be A - Z. May contain a hyphen (-) or a blank (.). No other special characters are allowed. Must be at least two characters.

CLAIM INFORMATIONAL - MESSAGE 6EA

CLAIM REJECT - MESSAGE 6EP

CA0-09.0 PATIENT SEX CODE

Valid values are: F = Female, M = Male

CLAIM INFORMATIONAL - MESSAGE 6EC

CLAIM REJECT - MESSAGE 6BA

CA0-11.0 PATIENT ADDRESS 1

CA0-13.0 PATIENT CITY

CA0-14.0 PATIENT STATE

CA0-15.0 PATIENT ZIP CODE

Enter the mailing address of the patient. First position of the address fields must not equal a space.

The patient's state must be a valid US Postal abbreviation.

The patient's zip code must be present unless the state code equals: CN, AS, MP, MH, MX, FM, PW, or FC. The first five characters must be numeric and the first three characters must be within the range for the state according to the US Postal Service.

CLAIM REJECT - MESSAGE 6EQ, 6ER, 6ES, 6ET

CA0-23.0 CLAIM EDITING INDICATOR

Must equal 'C' for Medicare.

DA0-02.0 RECORD SEQUENCE NUMBER

Sequence numbers must be sequential and must increment by one for each occurrence of the record. For each occurrence of the record type the sequences must be equal. Example:

DA001

DA101

DA002

DA102

CLAIM REJECT - MESSAGE 310, 311, 312

CLAIM WARNING - MESSAGE 319

DA0-04.0 CLAIM FILING INDICATOR

Must equal 'P' or 'I'. One DA0-04.0 must equal 'P'. Only one DA0-04.0 equal to 'P' allowed per claim. The 'P' identifies who the payment is being requested from. The 'P' should always be on the Medicare DA0 record when the receiver type code AA0-18.0 equals 'C'.

CLAIM REJECT - MESSAGE 304, 305, 306, 309

DA0-05.0 SOURCE OF PAYMENT

If DA0-04.0 = "P", then DA0-05.0 must = C.

If DA0-04.0 = "I", then DA0-05.0 may = any of the following values:

- A = Self Pay
- B = Workers Compensation
- D = Medicaid
- E = Other Federal Program
- F = Commercial Insurance Company
- G = Blue Shield
- H = Champus
- I = HMO
- J = Federal Employee's Program (FEP)
- K = Central Certification
- L = Self Administered
- M = Family or Friends
- N = Managed Care - Non-HMO
- P = Blue Cross
- T = Title V
- V = Veterans Administration Plan (VA)
- Z = Other (Medigap)

CLAIM REJECT - MESSAGES 302, 303, 304, 305, 306, 309

DA0-06.0 INSURANCE TYPE CODE

If DA0-05.0 = "C", DA0-06.0 must =

- MP = Medicare Primary
- 12 = Working aged beneficiary/spouse with employer group health plan.
- 13 = ESRD beneficiary in the 30 month coordination period with an employer's group health plan.
- 14 = No Fault Insurance Including Auto/Other
- 15 = Worker's Compensation
- 16 = PHS or Other Federal Agency
- 41 = Black Lung
- 42 = VA
- 43 = Disabled beneficiary under age 65 with LGHP
- 47 = Any Liability Insurance

If DA0-05.0 does not = "C", DA0-06.0 must =

- MG = Medigap Policy
- SP = Supplemental Policy
- IP = Individual Policy
- PP = Personal Payment (Cash - No Insurance)
- GP = Group Policy
- LT = Litigation
- AP = Auto Insurance Policy
- LD = Long Term Policy
- OT = Other

DA0-07.0 PAYOR ORGANIZATION IDENTIFICATION

When primary coverage is Medicare and secondary coverage is Medigap; the Medigap company code must be entered in this field on the second DA0 record.

DA0-09.0 PAYOR NAME

When primary is Medicare and secondary coverage is Medigap; the Medigap company name must be entered in this field on the second DA0 record when the unclassified company code of "99999" is entered in DA0-07.0.

DA0-14.0 PRIOR AUTH NO

Enter the Peer Review Organization (PRO) prior authorization number for those procedures requiring PRO prior approval.

DA0-15.0 ASSIGN OF BENEFITS IND

Must equal "Y" on second DA0 record to indicate authorization to cross claim to Medigap payor.

DA0-16.0 PAT SIGNATURE SOURCE

Valid values: C - Signed HCFA - 1500 claim form on file.
S = Signed signature authorization form for Block 12 on file.
M = Signed signature authorization form for Block 13 on file.
B = Signed signature authorization form or forms for both Block 12 and Block 13 are on file.
P = Signature generated by provider because the patient was not physically present for services.

Note: The M and P values will cause the claim to be returned as unprocessable. To avoid delay, a valid signature should be obtained prior to submitting a Medicare Part B claim.

CLAIM REJECT - MESSAGES 6BD, 6BE

DA0-17.0 PATIENT RELATIONSHIP TO INSURED

When DA0-05.0 equals "C", this field must equal 01 - Self.

DA0-18.0 INSURED IDENTIFICATION NUMBER

When DA0-05.0 equals "C", this field must contain the patient's Medicare Health Insurance Claim Number (HIC).

When DA0-05.0 equals "Z", this field must contain the patients Medigap policy number.

May only contain A-Z, 0-9. Embedded blanks are not valid. May not contain special characters such as: - / #.

CLAIM REJECT - MESSAGE 6E1

DA0-27.0 INSURANCE LOCATION IDENTIFIER

Enter the Choices identifier (plan contract number). The Medicare Choices Demonstration includes selected providers/Health Maintenance Organizations (HMO's) in targeted geographical areas selected by HCFA. This will be a five digit alpha-numeric HMO number assigned by HCFA.

DA1-02.0 RECORD SEQUENCE NUMBER

Sequence numbers must be sequential and must increment by one for each occurrence of the record. For each occurrence of the record type the sequences must be equal. Example:

DA001
DA101
DA002
DA102

CLAIM REJECT - MESSAGE 310, 311, 312

CLAIM WARNING - MESSAGE 319

DA1-04.0 PAYOR ADDR1

DA1-06.0 PAYOR CITY

DA1-07.0 PAYOR STATE

DA1-08.0 PAYOR ZIP

When DA0-05.0 equals "Z" and DA0-07.0 equals "99999", these fields must contain the address, city, state and zip code for the Medigap company.

DA1-11.0 ALLOWED AMOUNT

Must be submitted on DA1 record, sequence 01 when Medicare is the secondary payor. Reflects the total amount allowed by the primary payor.

DA1-14.0 PAYOR AMOUNT PAID

Must be submitted on DA1 record, sequence 01 when Medicare is the secondary payor. Reflects the total amount paid by the primary payor.

EA0-04.0 EMPLOYMENT RELATED INDICATOR

A code to indicate whether the patient alleges that his/her medical condition is due to the environment or events resulting from employment.

Valid values are: Y = Yes, employment related
N = No, not employment related
U = Unknown

CLAIM REJECT - MESSAGE: 6BB

EA0-05.0 ACCIDENT INDICATOR

A code to indicate whether the patient's condition was the result of an accident.

Valid values are: A = Auto accident
O = Other, non-auto accident
N = No accident

CLAIM REJECT - MESSAGE 6BC

EA0-13.0 RELEASE OF INFORMATION INDICATOR

A code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations in order to adjudicate the claim.
Valid values are: Y = Yes
M = Modified or restricted release on file
N = No release

EA0-20.0 REFERRING PROVIDER NATIONAL PROVIDER IDENTIFIER

Referring provider UPINs are required when the service was ordered or referred by a physician.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

CLAIM REJECT - MESSAGE 617, 673

EA0-24.0 REFERRING PROVIDER LAST NAME

When EA0-20.0 contains a UPIN/NPI, this field should contain the referring provider's last name.

EA0-30.0 LABORATORY INDICATOR

Must equal "Y" for all laboratory claims where tests were performed by a laboratory other than the billing laboratory. Referred laboratory services are identified by the "Y1" or "Y7" modifier in FA0-10.0 or FA0-11.0.

CLAIM REJECT - MESSAGE 680

EA0-31.0 LABORATORY CHARGES

When EA0-30.0 equals "Y", this field must contain the referral laboratory's charge for the service.

EA0-32.0 DIAGNOSIS CODE-1

EA0-33.0 DIAGNOSIS CODE-2

EA0-34.0 DIAGNOSIS CODE-3

EA0-35.0 DIAGNOSIS CODE-4

Claims will be rejected when the ICD-9-CM code is truncated. Please note that ICD-9-CM codes must be coded to the highest level of specificity, i.e., coding to the fourth or fifth digit.

Updated ICD-9-CM codes can be obtained from the American Hospital Association (AHA). There is no cost for an AHA member. There is a small fee for a non-member. The AHA toll-free number is 1-800-242-2626.

CLAIM REJECT - MESSAGE 636, 637

EA0-36.0 PROVIDER ASSIGNMENT INDICATOR

Valid values are: A = Assigned
 N = Not Assigned
 B = Assignment accepted on clinical lab services only.
 Non-clinical lab services will process as non-assigned.
 P = Patient refuses to assign benefits

CLAIM REJECT - MESSAGE 6BF

EA0-37.0 PROVIDER SIGNATURE ON FILE

The signature of the provider of service(s) reported on this claim which acknowledges the performance of the service(s) and authorizes payment is on file in the providers office.

Valid values are: Y = Signature of provider is on file.
 N = Signature of provider is not on file.

EA0-39.0 FACILITY / LABORATORY NAME

Enter the name of the facility here **and** the address of the facility in EA1-06.0, 08.0, 09.0, and 10.0 **or** the facility id number in EA1-04.0 if:

1. the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office.
2. modifiers "QB" or "QU" are entered in FA0-10.0 or 11.0 to refer to a Health Professional Shortage Area.
3. a physician maintains a dialysis patient and receives an monthly capitation payment. Enter the name and address or the facility's id number involved with the patient's maintenance of care and training.
4. modifier "Y1" or "Y7" is entered in FA0-10.0 or 11.0 to identify referred laboratory services.

When the name and address of the facility where the services were furnished is the same as the billing providers name and address, you may enter the word "SAME" in this field.

CLAIM REJECT - MESSAGE 649

EA0-43.0 SPECIAL PROGRAM INDICATOR

A code indicating the Special Program/Project under which the services rendered to the patient were performed.

Valid values are: 30 - Medicare Demonstration Project for Lung Volume Reduction Surgery Study

EA0-48.0 DATE LAST SEEN

Required when an independent physical or occupational therapist or physician providing routine foot care (M0101) submits claims.

EA0-50.0 HOMEBOUND INDICATOR

Required when an independent lab renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. Valid values are:

Y = Yes, patient is homebound
N = No, patient is not homebound

EA0-53.0 CARE PLAN OVERSIGHT (CPO) PROVIDER NUMBER

Enter the Medicare provider number for the Home Health Agency or Hospice providing Medicare covered services to the beneficiary for the period during which Care Plan Oversight services were furnished and for which the physician signed the plan of care. These services are billed using procedure codes G0064 or G0065.

EA0-54.0 INVESTIGATIONAL DEVICE EXEMPTION (IDE) NUMBER

Enter the investigational device exemption number for FDA-Approved clinical trials. Claims for investigational devices and/or services “incident to” the use of such devices must be identified with the HCPCS code plus the QA modifier.

EA1-04.0 FACILITY/LABORATORY NATIONAL PROVIDER IDENTIFIER (NPI)

Enter the facility id number here **or** the name of the facility in EA0-39.0 **and** the address of the facility in EA1-06.0, 08.0, 09.0 and 10.0 if:

1. the services were furnished in a hospital, clinic, laboratory, or facility other than the patient’s home or physician’s office.
2. modifiers “QB” or “QU” are entered in FA0-10.0 or 11.0 to refer to a Health Professional Shortage Area.
3. a physician maintains a dialysis patient and receives an monthly capitation payment. Enter the name and address or the facility’s id number involved with the patient’s maintenance of care and training.
4. modifier “Y1” or “Y7” is entered in FA0-10.0 or 11.0 to identify referred laboratory services.
5. billing for Assistant-at-surgery services (modifier 80, 81, or AS).
6. billing for the technical or total component of screening and diagnostic mammographies. Enter the six digit certification number.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

CLAIM REJECT - MESSAGE 625

EA1-06.0 FACILITY / LABORATORY ADDRESS 1

EA1-08.0 FACILITY / LABORATORY CITY

EA1-09.0 FACILITY / LABORATORY STATE

EA1-10.0 FACILITY / LABORATORY ZIP CODE

Enter the address of the facility here **and** the name of the facility in EA0-39.0 **or** the facility id number in EA1-04.0 if:

1. the services were furnished in a hospital, clinic, laboratory, or facility other than the patient’s home or physician’s office.
2. modifiers “QB” or “QU” are entered in FA0-10.0 or 11.0 to refer to a Health Professional Shortage Area.
3. a physician maintains a dialysis patient and receives an monthly capitation payment. Enter the name and address or the facility’s id number involved with the patient’s maintenance of care and training.
4. modifier “Y1” or “Y7” is entered in FA0-10.0 or 11.0 to identify referred laboratory services.

CLAIM REJECT - MESSAGE 627, 628, 629, 630, 681

EA1-16.0 SUPERVISING PROVIDER NATIONAL PROVIDER IDENTIFIER
Enter the UPIN of the attending physician when an independent physical therapist, or physician providing routine foot care (M0101) submits claims.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

FA0-02.0 RECORD SEQUENCE NUMBER
Sequence numbers must be sequential and must increment by one for each occurrence of the record. For each occurrence of the record type the sequences must be equal. Example:

FA001
FB001
FA002
FB002
GA002
HA002
FA003
GA003
HA003

CLAIM REJECT - MESSAGE 310, 331, 332

FA0-05.0 SERVICE FROM DATE
The date the service was initiated. Must be a valid date, must not be a future date and must be submitted in CCYYMMDD format.

CLAIM REJECT - MESSAGE 337, 640

FA0-06.0 SERVICE TO DATE
The Service To Date is not required unless billing for services performed over a range of dates. The date span of the From and To Dates must be within the same month and year, unless billing for radiation therapy procedures 77419, 77420, 77425, or 77430 and Care Plan Oversight procedures G0064 and G0065.

CLAIM REJECT - MESSAGE 337,641

FA0-07.0 PLACE OF SERVICE
Refer to Exhibit 4 for a list of valid place of service codes.

CLAIM REJECT - MESSAGE 648

FA0-09.0 HCPCS PROCEDURE CODE
Enter the specific procedures, services or supplies using the HCFA Common Procedure Coding System (HCPCS). Refer to page 1.4 for additional information on HCPCS procedure codes.

CLAIM REJECT - MESSAGE 660

FA0-10.0 HCPCS MODIFIER 1

FA0-11.0 HCPCS MODIFIER 2

Used to modify payment of a procedure or to assist in determining appropriate coverage.

Valid Medicare Part B modifiers: AD, AG, QK, QS, QX, QZ, 23, 47, 32, 80, 81, 82, AS, Z9, ZD, ZE, ZL, ZM, ET, Z4, Z5, 21, 24, 25, 57, AP, VP, QB, QU, AH, AJ, AM, EJ, E1, E2, E3, E4, FA, F1, F2, F3, F4, F5, F6, F7, F8, F9, GA, KM, KN, LC, LD, QA, QC, QD, QP, QT, QW, Q1, Q2, Q3, Q4, Q7, Q8, Q9, RC, SG, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, YR, Y1, Y7, 22, 52, 99, AK, AV, AL, AW, AY, AT, LT, Q5, Q6, RT, 20, 32, 50, 53, 54, 55, 56, 58, 59, 62, 66, 76, 77, 78, 79, AN, AU, LR, TC, 26, GC, GE.

The following modifiers should not be submitted on Medicare Part B claims.

These modifiers will be added during claims processing if appropriate:

51, CC, XU, XW, XY, XZ, XQ

Refer to APPENDIX A for a complete list of the Ambulance modifiers and their descriptions. Refer to Exhibit 3 for a description of the above modifiers.

CLAIM REJECT - MESSAGE 661, 662, 663, 664, 666

FA0-13.0 LINE CHARGES

Enter the charges related to this service. Must be positive unassigned numeric value.

CLAIM REJECT - MESSAGE 646

FA0-14.0 DIAGNOSIS CODE POINTER 1

Enter a pointer to the claim diagnosis code to relate the service performed to the appropriate diagnosis.

Valid values are:

1 = Pointer to diagnosis in EA0-32.0

2 = Pointer to diagnosis in EA0-33.0

3 = Pointer to diagnosis in EA0-34.0

4 = Pointer to diagnosis in EA0-35.0

CLAIM REJECT - MESSAGE 635

FA0-18.0 UNITS OF SERVICE

Must be equal to or greater than 00100. Must be equal to or less than 0990. This field should equal 0010 when anesthesia minutes are submitted in FA0-19.0.

CLAIM REJECT - MESSAGE 645

FA0-19.0 ANESTHESIA/OXYGEN MINUTES

Required when billing anesthesia services. Must be from 0001 to 0999.

CLAIM REJECT - MESSAGE 671

FA0-23.0 RENDERING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI)

Required if billing provider is a group practice. Enter the rendering providers individual provider number. Format requirements:

TEXAS: Six digit number. i.e., 8XXXXX.

MARYLAND: Eight digit number- first four digits equal the four digit billing provider number, the last four digits are unique for the individual doctor. i.e., Billing Provider Number equals "AAAA", rendering provider number equals "AAAABCDE".

DCMA/DE: Nine digit number - first six digits equal the individual provider number, the last three digits associate the provider with the group practice. i.e., Individual Provider Number equals "123456", Group provider number equals "456789" and the Group practice name is "Smith Clinic" - the rendering provider number will equal "123456S89".

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

CLAIM REJECT - MESSAGE 650, 651, 652

FA0-24.0 REFERRING PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI)

This field is **only** required for TEXAS AMBULANCE services. Enter the UPIN of the physician that was in communication with the ambulance during the transport and ordered the EKG (93005).

FA0-26.0 PURCHASED SERVICE INDICATOR

Required if diagnostic tests are billed on the claim. Valid values are:

N - Service was not purchased.

Y - Service was purchased from another entity.

When this field equals "Y", the following fields are required:

FB0-05.0 PURCHASED SERVICE CHARGE

FB0-11.0 PURCHASED SERVICE PROVIDER NPI

CLAIM REJECT - MESSAGE 670

FA0-34.0 CLINICAL LABORATORY IMPROVEMENT AMENDMENTS OF 1988 IDENTIFICATION NUMBER (CLIA)

All clinical diagnostic laboratory claims must include their CLIA number. Enter the ten digit CLIA number of the laboratory where each test was performed.

FA0-40.0 HOSPICE EMPLOYED PROVIDER IDENTIFIER

An indicator of whether or not the treatment in the hospice was rendered by a hospice employed physician. Valid values are:

Y - Yes, physician is employed by the hospice.

N - No, physician is not employed by the hospice.

FA0-41.0 HGB/HCT DATE

Required for Initial EPO therapy services (Q9920 - Q9940) with a diagnosis of 585 or 586. If submitted, date must be valid and formatted as CCYYMMDD.

CLAIM REJECT - MESSAGE 337

FA0-42.0 HEMOGLOBIN RESULT
Required for Initial EPO therapy services (Q9920 - Q9940) with a diagnosis of 585 or 586.

FA0-43.0 HEMATOCRIT RESULT
Required for Initial EPO therapy services (Q9920 - Q9940) with a diagnosis of 585 or 586.

FA0-44.0 PATIENT WEIGHT
Required for Initial EPO therapy services (Q9920 - Q9940) with a diagnosis of 585 or 586.

FA0-45.0 EPOETIN DOSAGE
Required for Initial EPO therapy services (Q9920 - Q9940) with a diagnosis of 585 or 586.

FA0-46.0 SERUM CREATINE DATE
Required for Initial EPO therapy services (Q9920 - Q9940) with a diagnosis of 585 or 586. If submitted, date must be valid and formatted as CCYYMMDD.

CLAIM REJECT - MESSAGE 337

FA0-47.0 CREATINE RESULT
Required for Initial EPO therapy services (Q9920 - Q9940) with a diagnosis of 585 or 586.

FB0-02.0 RECORD SEQUENCE NUMBER
Sequence numbers must be sequential and must increment by one for each occurrence of the record. For each occurrence of the record type the sequences must be equal. Example:

- FA001
- FB001
- FA002
- FB002
- GA002
- HA002
- FA003
- GA003
- HA003

CLAIM REJECT - MESSAGE 310, 332

FB0-05.0 PURCHASE SERVICE CHARGE
If FA0-26.0 equals "Y", this field must contain the suppliers charge to the billing provider for the technical portion of the diagnostic test.

CLAIM REJECT - MESSAGE 658

FB0-11.0 PURCHASE SERVICE PROVIDER NATIONAL PROVIDER IDENTIFIER (NPI)

If FA0-26.0 equals "Y", this field must contain the provider identification number of the entity that performed the technical portion of the diagnostic test.

This field must contain the National Provider Identifier (NPI) once the NPI is implemented.

CLAIM REJECT - MESSAGE 659

GA0-02.0 RECORD SEQUENCE NUMBER

Sequence numbers must be sequential and must increment by one for each occurrence of the record. For each occurrence of the record type the sequences must be equal. Example:

FA001
FB001
FA002
FB002
GA002
HA002
FA003
GA003
HA003

CLAIM REJECT - MESSAGE 310, 332

GA0-08.0 BED CONFINED - BEFORE

A code to indicate whether the patient was bed confined before the ambulance service. Valid values are: Y = Patient was bed confined.
N = Patient was not bed confined.

GA0-09.0 BED CONFINED - AFTER

A code to indicate whether the patient was bed confined after the ambulance service. Valid values are: Y = Patient was bed confined.
N = Patient was not bed confined.

GA0-10.0 MOVED BY STRETCHER

A code to indicate whether the patient was moved by stretcher. Valid values are: Y = Patient was moved by stretcher.
N = Patient was not moved by stretcher.

GA0-11.0 UNCONSCIOUS / SHOCK

A code to indicate whether the patient was unconscious or in shock. Valid values are: Y = Patient was unconscious or in shock.
N = Patient was not unconscious or in shock.

GA0-12.0 EMERGENCY SITUATION

A code to indicate whether the patient was transported in an emergency situation. Valid values are: Y = Emergency situation.
N = Not an emergency situation.

GA0-13.0 PHYSICAL RESTRAINTS

A code to indicate whether the patient had to be physically restrained.

Valid values are: Y = Physical restraints needed.
 N = No physical restraints used.

GA0-14.0 VISIBLE HEMORRHAGING

A code to indicate whether the patient had visible hemorrhaging.

Valid values are: Y = Visible hemorrhaging noted.
 N = No visible hemorrhaging noted.

GA0-15.0 TRANSPORTED TO/FOR

A code to indicate whether the patient was transported to the nearest facility or for other considerations. Patient was transported:

- A = To nearest facility for are of symptoms and/or complaints.
- B = for the benefit of a preferred physician.
- C = For the nearness of family members.
- D = for the care of a specialist or for availability of specialized equipment.

Note: When this field equals 'D', GA0-24.0 is required.

GA0-18.0 ORIGIN INFORMATION

Free form description field used to provide the address of the origin. Should include the street address, city, state (only if the state differs for the origin and destination). Refer to Appendix A for additional information on ambulance requirements.

GA0-19.0 DESTINATION INFORMATION

Free form description field used to provide the address of the destination. Should include the street address, city, state (only if the state differs for the origin and destination). Refer to Appendix A for additional information on ambulance requirements.

GA0-20.0 PURPOSE OF ROUND TRIP

This field may be used to provide any additional information that is required to ensure accurate processing of your ambulance claim.

GA0-21.0 PURPOSE OF STRETCHER

This field may be used to provide any additional information that is required to ensure accurate processing of your ambulance claim.

GA0-24.0 SERVICES AVAILABLE AT FACILITY

Required when patient is being transported from one facility to another. A code to indicate whether services provided at the second facility were available at the first.

Valid values are:
Y - Yes, services were available at the first facility.
N - No, services were not available at the first facility.

GC0-02.0 RECORD SEQUENCE NUMBER

Sequence numbers must be sequential and must increment by one for each occurrence of the record. For each occurrence of the record type the sequences must be equal. Example:

FA001
FB001
FA002
FB002
GC002
HA002
FA003
GC003
HA003

CLAIM REJECT - MESSAGE 310, 332

GC0-05.0 INITIAL TREATMENT DATE

Date that the patient initially sought treatment for this condition. Must be a valid date and must be in CCYYMMDD format.

CLAIM REJECT - MESSAGE 137

GC0-06.0 DATE OF LAST X-RAY

Enter the date of the x-ray taken at a time reasonably proximate to the initiation of treatment. An x-ray will be considered to be reasonable proximate if it was taken no more than 12 months prior to or 3 months following the initiation of a course of chiropractic treatment.

CLAIM REJECT - MESSAGE 137

HA0-02.0 RECORD SEQUENCE NUMBER

Sequence numbers must be sequential and must increment by one for each occurrence of the record. For each occurrence of the record type the sequences must be equal. Example:

FA001
FB001
HA001
FA002
FB002
GC002
HA002
FA003
GC003
HA003

CLAIM REJECT - MESSAGE 310, 332

HA0-05.0 EXTRA NARRATIVE DATA

Submit the following information as necessary:

- Enter the drug's name, dosage and charge when submitting Not Otherwise Classified (NOC) Drug codes.
- Enter a coherent description of services rendered when Not Otherwise Classified (NOC) procedure codes are submitted.
- Enter the procedure code and all applicable modifiers when modifier "99" - Multiple Modifiers, is entered in FA0-11.0.
- Enter the statement, "Testing for Hearing Aid" when submitting claims to obtain intentional denials when other payors are involved.
- Enter the specific surgery performed, when a dental exam is billed.
- Enter the specific name and dosage amount when low osmolar contrast material is billed and there is no HCPCS code to cover them.
- Enter the assumed and relinquished date for a global surgery claim when providers share post-operative care.
- Enter the method of submission and the date if utilizing the FAX/MAIL option. Refer to Appendix F for further instructions.

CLAIM REJECT - MESSAGE 674

DATE ALL DATE FIELDS

If submitted, must be valid dates in CCYYMMDD format.

CLAIM REJECT - MESSAGE 337, 640, 641

STATE ALL STATE FIELDS

If submitted, must be valid two-digit state postal abbreviation.

CLAIM REJECT - MESSAGE 6ES, 629

ZIP ALL ZIP CODE FIELDS

If submitted, must be five (5) numerics or nine (9) numerics. May not contain hyphens. The first three characters of the zip code must be within the range for the state according to the U.S. Postal Service.

CLAIM REJECT - MESSAGE 6ET, 630

For a complete list of reject messages, refer to Exhibit 4.

MEDICARE PART B - GENERAL INFORMATION

- **BENEFICIARY SIGNATURE REQUIREMENTS:**

Under current procedures, the signature of the beneficiary (or his representative) is normally required on each claim. However, physicians and other suppliers may, in certain cases, obtain a beneficiary's authorization for the submission of claims over an extended period of time. To simplify the submission and processing of Part B claims, the requirements for signature authorizations have been broadened by: (1) permitting a physician (or other supplier, in most cases) to obtain from the beneficiary and retain in the physician's files a lifetime authorization for the physician to submit assigned and non-assigned claims on the beneficiary's behalf; (2) permitting a hospital or other provider to obtain from the beneficiary at the time of admission, and retain in its files, an authorization, effective for the period of confinement, for the provider and for any physician to submit assigned and non-assigned claims on the beneficiary's behalf for services furnished by the provider on an inpatient basis; and (3) permitting a hospital or other provider to obtain from the beneficiary at the start of outpatient care, and retain in its files, a lifetime authorization for the provider and for any physician to submit assigned and non-assigned claims on the beneficiary's behalf for services furnished by the provider on an outpatient basis.

These broadened instructions also permit physicians, independent laboratories, and other suppliers submitting a claim for diagnostic tests or test interpretations to sign the claim on behalf of the beneficiary if the service is performed without personal contact with the beneficiary. This rule does not apply, however, where the service is performed in a medical facility which is visited by the beneficiary, or where a representative of the facility visits the beneficiary, in connection with the service.

Any person or entity submitting assigned or non-assigned claims under the above procedures must complete and submit promptly the appropriate Medicare claim form in all cases and include on any bill sent to a beneficiary, notice that the bill is not to be used for Medicare claims purposes.

The authorization statements have been revised but language approved under current instructions may continue to be used until it is practicable to substitute the new language. Authorizations that contain the existing language are subject to any restrictions and limitations reflected in that language.

Extended Payment Request for Physician Services: Generally, the payment authorization on the Medicare claim form applies only to the particular services listed on the form. However, a physician may obtain and retain in his files a one time payment authorization from a patient or his representative applicable to any current and future treatment that the physician may furnish.

The physician should have the patient sign a brief statement substantially as follows:

Name of Beneficiary

HI Claim #

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Once the physician has obtained the patient's one time authorization, he may submit any later Medicare claims, on either an assigned or non-assigned basis, without obtaining any additional signatures of the patient. In submitting claims, he should indicate in the patient's signature space: "patient's request for payment on file". On electronic claims this is done by entering C, S, M, B or P in the Patient Signature Source field (DA0-16.0) and a "Y" in the Release of Information Indicator field (EA0-13.0). Refer to Section 12 for more information on these fields.

- **DIAGNOSIS CODE REQUIREMENTS**

- Claims will be rejected as unprocessable when the ICD-9-CM code used is invalid. Please note that ICD-9-CM codes must be coded to the highest level of specificity, i.e., coding to the fourth or fifth digit when appropriate.
- Physicians should code diagnoses to the highest degree of certainty documented at the time of the visit.

Example:

A patient visited a medical clinic with a chief complaint of a headache. On physical examination, the physician noted a questionable weakness on the patient's right side and ordered a CT scan of the head to "rule out brain tumor". The physician should not code brain tumor as if it were an established condition. Headache, code 784.0, should be shown as the reason for the visit.

- Chronic diseases treated on an ongoing basis should be coded and reported as many times as the patient receives services for the condition. However, previously treated conditions which no longer exist should not be included on the claim or physician's statement.
- Independent laboratories are not required to submit diagnosis codes except on limited coverage procedures and on claims for Medicare ESRD patients.
- Failure by physicians to provide the required ICD-9-CM code(s) will result in claims being rejected as unprocessable.
- If the request for payment does not include the required code(s), and the physician refuses to provide the codes promptly to the carrier, the physician may be subject to a civil monetary penalty in an amount not to exceed \$2,000; and

- If the physician repeatedly fails to provide the requested code(s), the physician may be subject to sanctions.
- For Medicare purposes; physicians are defined as doctors of medicine, doctors of osteopathy, dentists, optometrists, chiropractors, and podiatrists.

- **EMC BILLING LIMITATIONS:**

There are no claim types that are not accepted in National Standard Format. If you have questions regarding specific services/claim types, please contact your EMC Marketing Representative.

- **CLAIMS REQUIRING SUPPORTING DOCUMENTATION**

Certain services require supporting documentation for correct claim processing.

Refer to FAX/MAIL EMC Documentation Appendix F for a list of services and instructions.

- **SPECIFIC CLAIM TYPE REQUIREMENTS**

- **AMBULANCE CLAIMS**

Require the fields as defined on the GA0 record.

- **ANESTHESIA CLAIMS**

Claims for anesthesia services are to be submitted using the CPT-4 anesthesia procedure codes (00100-01999) with the appropriate modifier. **Surgery codes are not accepted unless the anesthesiologist or CRNA is performing the surgical procedure being billed.**

- **CARE PLAN OVERSIGHT**

Enter the Medicare provider number for the Home Health Agency or Hospice providing Medicare covered services to the beneficiary for the period during which Care Plan Oversight services were furnished and for which the physician signed the plan of care. These services are billed using procedure codes G0064 or G0065.

- **CHIROPRACTIC CLAIMS**

Require the fields as defined on the GCO record.

- **CLINICAL PATHOLOGY CONSULTATIONS**

Enter the referring physician's UPIN in field EA0-20.0.

Enter the referring physician's name in the following fields:

EA0-22.0 - Referring Provider Last Name

EA0-23.0 - Referring Provider First Name

EA0-24.0 - Referring Provider Middle Initial

Enter the HCPCS procedure codes of the performed tests in field HA0-05.0.

- **INDEPENDENT PHYSICAL OR OCCUPATIONAL THERAPIST, OR PHYSICIAN PROVIDING ROUTINE FOOT CARE**

Must submit the following:

UPIN of Ordering/referring Physician	EA0-20.0
Name of Ordering/referring Physician	EA0-22.0
Date Patient was Last Seen by Attending Physician	EA0-46.0
UPIN of Attending Physician	EA1-16.0

- **INITIAL EPO CLAIMS**

The following fields may be used to provide the necessary information on initial EPO services. These fields may be used in lieu of the EPO fax documentation form.

HGB/HCT Date	FA0-41.0
HGB Result	FA0-42.0
HCT Result	FA0-43.0
Patient Weight	FA0-44.0
EPO Dosage	FA0-45.0
Serum Creatine Date	FA0-46.0
Creatine Result	FA0-47.0

- **MEDICARE PRIMARY - NO SECONDARY**

To submit a Medicare primary coverage claim with no secondary insurance, use only one DA0 record. Complete the fields as indicated.

<u>Field</u>	<u>Enter</u>
01.0	Must be DA0
02.0	Must be 01
04.0	Must be P
05.0	Must be C
06.0	Must be MP
16.0	Must be C, S, M, B, or P.
18.0	Must be patient's HIC number (omit spaces, hyphens, etc.)

- **MEDICARE PRIMARY - MEDIGAP SECONDARY**

To submit a Medicare primary coverage claim with secondary Medigap coverage requires two DA0 records.

Complete the first DA0 record as indicated under Medicare Primary - No Secondary.
Complete the second DA0 record as indicated below.

<u>Field</u>	<u>Enter</u>
01.0	Must be DA0
02.0	Must be 02
04.0	Must be 'T'
05.0	Must be Z
06.0	Must be MG
07.0	*Must enter Medigap Company Code.
09.0	Must enter Payor name if using '99999' as company code.
15.0	Must be Y
18.0	Must enter patient's Medigap policy number. (Omit spaces,hyphens, etc.)

*If the Medigap Company Code is unknown, enter '99999' as the company code. When it is necessary to use '99999' you must complete a DA1 record, sequence 02 as indicated:

<u>Field</u>	<u>Enter</u>
01.0	Must be DA1
02.0	Must be 02
04.0	Payor Address
06.0	Payor City
07.0	Payor State
08.0	Payor Zip

- **MEDICARE PRIMARY - OTHER SECONDARY**

To submit a Medicare primary coverage claim with secondary insurance coverage other than Medicaid, Medigap or Texas Blue Shield, requires two DA0 records in the following formats:

Complete the first DA0 record as indicated under Medicare Primary - No Secondary.
Complete the second DA0 record as indicated.

<u>Field</u>	<u>Enter</u>
01.0	Must be DA0
02.0	Must be 02
04.0	Must be 'T'
05.0	Must be other than: C, D, G, J, or Z
06.0	Must be other than: MG, MP, 12, 13, 14, 15, 16, 41, 42, 43, or 47.
18.0	Is Ignored.

- **MEDICARE PRIMARY - MEDICAID SECONDARY**

It is not necessary to provide policy information on Medicare primary, Medicaid secondary recipients. The crossover to Medicaid is based on an eligibility file that is provided to us by Medicaid on a monthly basis. If your claims are not crossing over, you must contact Medicaid directly for assistance.

- **MEDICARE PRIMARY - BLUE SHIELD SECONDARY**

It is not necessary to provide policy information on Medicare primary, Blue Shield secondary recipients. The crossover to Blue Shield is based on an eligibility file that is provided to us by Blue Shield on a monthly basis. If your claims are not crossing over, you must contact Blue Shield directly for assistance.

- **MEDICARE SECONDARY**

To submit a MSP claim electronically does not require the submission of the primary payor's explanation of benefits but does require the submission of three additional data elements:

- Insurance Type Code
- Payor Amount Paid
- Allowed Amount

Insurance Type Code (Field DA0-06.0, positions 25-26, DA0 sequence 02)

enter one of the following values:

- 12 = Working Aged Beneficiary/Spouse with Employer Group Health Plan
- 13 = ESRD Beneficiary in the 30th month
- 14 = No Fault Insurance including Auto/Other
- 15 = Worker's Compensation
- 16 = PHS or Other Federal Agency
- 41 = Black Lung
- 42 = VA
- 43 = Disabled Beneficiary Under Age 65 with LGHP
- 47 = Any Liability Insurance

Payor Amount Paid (Field DA1-14.0, positions 149-155, DA1 sequence 01)

Enter the total amount paid by the primary payor on the claim. If no payment was made, zero fill this field.

Allowed Amount (Field DA1-11.0, positions 128-134, DA1 sequence 01)

Enter the total amount allowed for the services on the claim by the primary payor. If no amount was allowed, zero fill this field.

- **MODIFIER 20 - MICROSURGERY**
 When the surgical service is performed using the techniques of microsurgery, including the aid of an operating microscope. The use of this modifier is not warranted when surgery is done with the aid of a magnifying loupe or magnifying binoculars worn by the surgeon. The HA0-05.0 should be used to provide the FAX/MAIL date and mode of submission of the documentation supporting the necessity of the microsurgical approach.

- **MODIFIER 22 - UNUSUAL SERVICES**
 When the service(s) provided is greater than that usually required for the listed procedure, these claims will suspend for pricing. An operative report must be with the claim. This modifier should only be reported with procedure codes that have a global period of 0, 10, or 90 days. Field HA0.05.0 may be used to provide a concise statement about how the service differs from the usual and provide the FAX/MAIL date and mode of submission of the operative report. Claims received with the -22 modifier and without the additional information will be processed as though the -22 modifier were not present.

- **MODIFIER 52 - REDUCED SERVICES**
 When the service(s) provided is significantly less than that usually required for the listed procedure. A concise statement about how the service differs from the usual and an operative report must be with the claim. This modifier can be submitted with any surgical procedure. Field HA0.05.0 may be used to provide a concise statement about how the service differs from the usual and provide the FAX/MAIL date and mode of submission of the operative report. Assigned claims received with the -52 modifier and no additional information will be denied; non-assigned claims will be delayed while the additional information is requested.

- **MODIFIER 99 - MULTIPLE MODIFIERS**
 More than 2 modifiers may be necessary to completely delineate a service. List one modifier in the first modifier field (FA0-10.0) and "99" in the second modifier field (FA0-11.0). Use a HA0-05.0 to identify the procedure code and all of the applicable modifiers. Example: 73600 - WP, TC, 50, QB

- **MODIFIERS NOT FOR EMC USE**
 The following modifiers should not be submitted on Medicare Part B claims. These modifiers are plugged internally or by the system.
 51, CC, EM, W1, W8, Z9

- **NOT OTHERWISE CLASSIFIED PROCEDURE CODES**

All efforts should be made to file a claim using valid specific HCPCS codes. If a specific HCPCS code cannot be used, NOC codes can be submitted electronically if these guidelines are followed.

- When a NOC code is billed, the procedure description must be submitted in HA0-05.0. NOC codes submitted without procedure descriptions will be rejected as unprocessable.
- If sufficient documentation cannot be submitted electronically, refer to the FAX/MAIL EMC Documentation Appendix.
- If you believe a code should exist for a certain procedure but cannot find a code, contact the Medicare Part B Provider Lines. These phone numbers are listed in Exhibit 5.

- **PACEMAKER SYSTEMS**

When procedures 93733 or 93736 are billed, the following requirements apply. Enter the prescribing physician's UPIN in field EA0-20.0

Enter the prescribing physician's name in the following fields:

- EA0-22.0 - Referring Provider Last Name
- EA0-23.0 - Referring Provider First Name
- EA0-24.0 - Referring Provider Middle Initial

- **POSTOPERATIVE MANAGEMENT ONLY**

When billing for postoperative management only, modifier 55 must be entered in FA0-10.0 (HCPCS Modifier 1) or FA0-11.0 (HCPCS Modifier 2) and the surgical procedure code must be entered in FA0-09.0. The Service To Date (FA0-06.0) must be blank filled. If billing for 90 days, enter the Units of Service (FA0-18.0) as 0010. If billing for fewer than 90 days, enter the exact number of days in the Units of Service (FA0-18.0). The date care was assumed and relinquished must be entered in HA0-05.0.

- **PURCHASE DIAGNOSTIC TESTS**

Procedures which meet the definition of "diagnostic tests", are required to indicate "No Purchased Services" or the suppliers number and charge for the technical portion. If the technical portion of the test was not purchased enter 'N' in the FA0-26.0. If the technical portion of the test was purchased, the following fields are required:

- FA0-26.0 - must = Y
- FB0-05.0 - must = suppliers charge for the technical portion.
- FB0-11.0 - must = suppliers Medicare provider number.

Note: These fields are required for each diagnostic test where the technical portion was purchased. Failure to provide either the 'N' or the purchased test information will result in rejection of your claims.

- **REFERRAL LAB BILLING**

Laboratories billing under the 30 percent exemption, must report a Y1 modifier with the referral test. Laboratories billing under the subsidiary-related exemption, must report a Y7 modifier with the referred test. In both cases, enter the name, address and provider number (if available) of the performing lab in the following fields:

EA0-28.0 - Laboratory Indicator, must = Y

EA0-37.0 - Enter Facility/Laboratory Name

EA1-04.0 - Enter Facility/Laboratory ID #

EA1-06.0 thru 10.0 - Enter Facility/Laboratory Address

MEDICARE PART B - TEST DATA

Section 3 of this Implementation Guide describes the testing process. We recommend that new EDI System Vendors and Submitters include the following claim situations when testing Medicare Part B. Testing each of these situations, will ensure that all possible claims processing situations have been tested.

General Claims -

- Multiple Place of Services (11, 12, 21, 22, 32...)
- Referring Provider UPINs (X-ray, Lab, Consultations, Physical Therapy)
- Medigap for Participating Providers
- Secondary Insurance (Blue Cross Blue Shield, Medical Assistance, Commercial)
- Medicare Secondary Payor (MSP) Claims
 - (Paid Amount, Allowed Amount, Insurance Type Code)
- Narratives
- Modifiers
- Assistant Surgery (Mod 80 - with Facility ID)
- Multiple Surgery's
- Solo Practice
- Group Practice (with Performing Provider Id #'s)
- Purchased Test (with Indicator, Amount, Prov ID)
- 12 Detail lines

Specialty Claim Types -

- Anesthesia/CRNA (with modifiers, minutes)
- Independent Labs
- Independent Radiology
- Reference Labs
- Ambulance - Include claims for mileage, supplies, and round trip transfers.
- Podiatry
- Chiropractor
- Physical Therapy
- EPO (with Initial EPO visits)

MEDICARE PART B - ANSI IMPLEMENTATION GUIDELINES

Following are guidelines / information that will assist you in implementing the ANSI X12 837 transaction set, versions 3030.2B, 3051.3B and 3051.3B.01 for Medicare Part B claims.

- You must contact our office and be set up as a trading partner prior to submitting ANSI transactions.
- A test file must be submitted and approved prior to submitting production claims.
- 837 ANSI transaction files equal to or greater than 1 Mg. will be held and processed in the nightly batch cycle. The response files will be available the next day. You will receive a message to this effect immediately, when your file is being processed in this manner.
- A “ZZ” qualifier was added to all of the NM1 segments in version 3051-3B.01 to designate National Provider Identifier (NPI). These fields must contain the “ZZ” qualifier and the National Provider Identifier (NPI) once the NPI is implemented.
- In addition to the 997 acknowledgment, you will receive our formatted response file which will provide you with file/batch/claim status information. Since the ANSI transaction is translated immediately into National Standard Format (NSF) for editing and processing, the response file will reference NSF fields and values. You will need a copy of the Texas Health Information Network Implementation Guide to assist you in resolving any rejects you may encounter. Appendix “C” of the ANSI Implementation Guides provide a crosswalk between ANSI data elements and NSF fields.
- We have implemented the ANSI X12 837 for Medicare Part B based on the HCFA Medicare Part B Specifications for the ANSI X12 Implementation Guide. You may obtain a copy of the guide from the following web site:

<http://www.hcfa.gov>

- Following are definitions for specific data elements and their requirements that are unique to Medicare Part B:

0-010-ISA - INTERCHANGE CONTROL HEADER

ISA04 - Must equal the password for the submitter id in ISA06, based on the THIN database.

ISA06 - Must equal the 6 digit submitter id, based in the THIN database.

ISA08 - Must equal ‘C00900’ for Texas, ‘C00901’ for Maryland, ‘C00902’ for Delaware, ‘C00903’ for the DC Metroplex.

1-010-BGN - BEGINNING SEGMENT

BGN02 - Only the first six bytes are acknowledged by THIN. This number must be unique for each submission since duplicate file checking is performed. If the file id number matches a previously transmitted file from the same submitter, it will be rejected as a duplicate file at the time of transmission.

1-020-NM1 - SUBMITTER NAME AND ID

NM109 - Must equal the six digit submitter id, based on the THIN database.

1-020.R-NM1 - RECEIVER NAME AND ID

NM108 - Must equal "94".

NM109 - Must equal 'C00900' for Texas, 'C00901' for Maryland, 'C00902' for Delaware, 'C00903' for the DC Metroplex.

2-005-PRV - BILLING PROVIDER

PRV02 - Must equal "1C".

PRV03 - Must equal the Medicare Part B provider number.

Note: A "ZZ" qualifier was added in version 3051-3B.01 to designate National Provider Identifier (NPI). These fields must contain the "ZZ" qualifier and the National Provider Identifier (NPI) once the NPI is implemented.

2-035 - BATCH IDENTIFICATION

REF02 - Only the first six bytes are acknowledged by THIN. This number must be unique for each REF02 segment since duplicate batch checking is performed. If the batch id number matches a previously transmitted batch from the provider in 2-005-PRV, it will be rejected as a duplicate batch at the time of transmission.

2-095.LR-NM1 - LEGAL REPRESENTATIVE

This segment is not acknowledged by the Medicare Part B claims processing system.

2-105.LR-N3 - LEGAL REPRESENTATIVE ADDRESS

This segment is not acknowledged by the Medicare Part B claims processing system.

2-1110.LR-N4 - LEGAL REPRESENTATIVE CITY, STATE, ZIP

This segment is not acknowledged by the Medicare Part B claims processing system.

2-120.LR-PER - LEGAL REPRESENTATIVE TELEPHONE NUMBER

This segment is not acknowledged by the Medicare Part B claims processing system.

2-155-PWK - PAPERWORK

This segment is not acknowledged by the Medicare Part B claims processing system. The NTE segment is used to provide narrative information and to provide the FAX/MAIL option information.

2-180-REF - PRIOR AUTHORIZATION NUMBER

REF01 - G1 Qualifier = Prior Authorization Number
X4 Qualifier = CLIA ID Number
LX Qualifier = Qualified Products List (IDE Exemption)
P4 Qualifier = Project Code (Medicare Demonstration Project)

REF02 = Prior Authorization Number / CLIA ID Number / Investigational Device
Exemption Number / Medicare Demonstration Number

2-290-SBR - ADDITIONAL PAYER INFORMATION

SBR01 - The Medicare Part B claims processing system does not acknowledge the
“T - Tertiary” payer information.

2-370-SV1 - PROFESSIONAL SERVICE

SV101-05 and -06 - The Medicare Part B claims processing system does not
acknowledge these data elements.

SV107-02, -03, and -04 - The Medicare Part B claims processing system does not
acknowledge these data elements.

2-405-SV6 - ANESTHESIA SERVICE

SV601-05 and -06 - The Medicare Part B claims processing system does not
acknowledge these data elements.

SV605-02, -03, and -04 - The Medicare Part B claims processing system does not
acknowledge these data elements.

SV606 - Enter the actual number of minutes the patient was anesthetized.