



## Provider Inquiry Assistance

### Instructions for Processing Claims Containing Anti-Markup Services but with Partial Information Completed in Item 20 of the CMS-1500 Claim Form – JA6670

**Note:** MLN Matters® MM6670 was revised to reflect a revised Change Request (CR) 6670 that was issued on January 29, 2010. The CR release date, transmittal number, and the Web address for accessing CR6670 were revised.

Related CR Release Date: January 29, 2010 **Revised**

Date Job Aid Revised: February 4, 2010

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

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**Key Words** MM6670, CR6670, R1903CP, CR6122, MM6122, R1589CP, Anti-Markup

**Contractors Affected**

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Medicare Carriers

**Provider Types Affected** Physicians and other providers submitting claims to Medicare Carriers and/or A/B MACs for services provided to Medicare beneficiaries



CR6670 provides instructions for processing claims for diagnostic services that are subject to the "anti-markup payment limitation" and that are billed with missing or incomplete information in Item 20 of the form CMS-1500 or its electronic equivalent.

- Medicare contractors will use the following guidelines for determining whether a claim contains a diagnostic service that is subject to the "anti-markup payment limitation":
  - If a "Yes" or "No" is not indicated in Item 20 and the associated dollar amount is missing, contractors will assume the service is not subject to the "anti-markup payment limitation" and will process the claim accordingly;
  - If a "Yes" or "No" is not indicated in Item 20 and the associated dollar amount is present, contractors will return the claim to the provider as unprocessable;
- If the "Yes" box is marked in Item 20 and the associated dollar amount is missing, contractors will return the claim as unprocessable;
- If the "No" box is marked in Item 20 and the associated dollar amount is present, contractors will return the claim as unprocessable.

**Provider Needs to Know...**

**Note:** In accordance with the requirements of the "anti-markup payment limitation", Medicare contractors will apply the above logic to both the technical component and the professional component of diagnostic tests.

- These guidelines apply to both the CMS-1500 and its electronic equivalent.

**Background**

- The *Medicare Claims Processing Manual* (Chapter 1, Section 80.3.2.1.2 ) establishes guidelines for processing of claims for diagnostic services **when:**
  - There is no entry for the "Yes/No" indicator in Item 20 of the CMS-1500 claim form, or
  - The American National Standards Institute X12 837P electronic claim is missing a claim or line level PS1 segment to indicate whether the diagnostic services were purchased.
- CR6122 (Transmittal 1589, September 8, 2008) instructed the Medicare contractor to assume that a diagnostic service was not purchased when there is no "Yes/No" indicator marked in Item 20 of the paper claim form or its electronic equivalent.
- Additionally, the instructions referred to anti-markup as it was formerly known as "purchased diagnostic tests" and applied only to the technical component of a diagnostic test.

**Operational Impact**

N/A

Reference  
Materials

The related MLN Matters® article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6670.pdf> on the CMS website.

The official instruction (CR6670) regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1903CP.pdf> on the CMS website.

The related MLN Matters® article for CR6122 can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/mm6122.pdf> on the CMS website.

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