CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3086	**Date: October 3, 2014**
	Change Request 8687

SUBJECT: Update to Pub. 100-04, Chapter 1 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

I. SUMMARY OF CHANGES: This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 1. Additionally, references to CMS contractor types have been replaced with Medicare Administrative Contractors (MACs) in the sections that are updated by this transmittal. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications. Also Exhibit 1-Data Element Matrix (FI) is deleted. It is out of date and will not be updated. Similarly section 80.3.2.1, which refers to the Matrix is deleted.

EFFECTIVE DATE: ICD-10: Upon Implementation of ICD-10; ASC X12: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: ASC X12: November 4, 2014, ICD-10: Upon Implementation of ICD-10

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	01/ Foreword
N	01/ 02/ Formats for Submitting Claims to Medicare
N	01/ 02.1/ Electronic Submission Requirements
N	01/02.1.1/ HIPAA Standards for Claims
N	01/02.1.2/ Where to Purchase HIPAA Standard Implementation Guides
N	01/02.2/ Paper Claims
N	01/02.2.1/ Paper Formats for Institutional Claims
N	01/02.2.2/ Paper Formats for Professional and Supplier Claims
N	01/02.3/ Remittance Advices
R	01/10.1.1/ Payment Jurisdiction Among Local A/B MACs for Services Paid Under the Physician Fee Schedule and Anesthesia Services
R	01/10.1.1.1/ Claims Processing Instructions for Payment Jurisdiction
R	01/30.2.9/ Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-01/Markup Payment Limitation/ Claims Submitted to A/B MACs (B)
R	01/30.2.13/ Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment/ for A/B MACs(B) Processed Claims
R	01/30.3.7/ Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) Subject to the Anti-Markup Payment Limitation/ Claims Submitted to AB/MACs(B)
R	01/50.1.1/ Billing Form as Request for Payment
R	01/50.1.2/ Beneficiary Request for Payment on Provider Record – Institutional Claims ASC X12 837 Institutional Claim Format and Form CMS 1450
R	01/50.1.7/ Definition of a Claim for Payment
R	01/50.3.2/ Policy and Billing Instructions for Condition Code 44
R	01/60.1/ General Information on Non-covered Charges on Institutional Claims
R	01/70.1/ Determining Start Date of Timely Filing Period -- Date of Service
R	01/70.2.2/ Form Prescribed by CMS
R	01/70.2.3/ In Accordance with CMS Instructions
R	01/70.2.3.2/ Handling Incomplete or Invalid Submissions
R	01/70.8.4/ Claims Forms CMS 1490S and CMS-1450
D	01/80.3.2.1/ Data Element Requirements Matrix
R	01/80.3.2.1.2/ Conditional Data Element Requirements for A/B MACs (B) and DME MACs

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	01/80.3.2.1.3/ A/B MAC(B) Specific Requirements for Certain Specialties/ Services
R	01/80.3.2.2/ Consistency Edits for Institutional Claims
R	01/130.2/ Inpatient Part A Hospital Adjustment Bills
R	01/190/ Payer Only Codes Utilized by Medicare
D	01/Exhibit 1 – Data Element Requirements Matrix (FI)

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3086	Date: October 3, 2014	Change Request: 8687

SUBJECT: Update to Pub. 100-04, Chapter 1 to Provide Language-Only Changes for Updating ICD-10 and ASC X12

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I. GENERAL INFORMATION

A. Background: This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 1.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8687.1	A/B MACs and CEDI shall be aware of the updated language in this CR for ICD-10 and for ASC X12 in Chapter 1 of Pub. 100 - 04.	X	X	X	X					CEDI, RRB-SMAC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

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:
	Not Applicable

Section B: All other recommendations and supporting information: Not Applicable

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable

Post-Implementation Contact(s): Contact your Contracting Office Representative (COR)

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 does 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev.3086, Issued: 10-03-14)

01 - Foreword

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

Generally, this chapter describes policy applicable to Medicare fee-for-service claims, or what is known as the original or traditional Medicare program. See the Medicare Managed Care Manual for services to enrollees in managed care plans.

Unless specified otherwise the instructions in this chapter apply to both providers and suppliers, and to the contractors that process their claims.

In this chapter the terms provider and supplier are used as defined in 42 CFR 400.202.

- Provider means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech-language pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

- Supplier means a physician or other practitioner, or an entity other than a provider that furnishes health care services under Medicare. A supplier must meet certain requirements and enroll as described in Chapter 10 of the Medicare Program Integrity Manual. A provider that meets the applicable conditions may also enroll as a supplier of a particular service and may bill separately for that service where Medicare payment policy allows separate payment for the service.

In this chapter and in subsequent chapters of Pub. 100-04, the terms 'institutional claim' and 'professional claim' are defined by the submission format of the claim.

- Institutional claim means any claim submitted using the Health Insurance Portability and Accountability Act (HIPAA) mandated transaction ASC X12 837 *i*nstitutional *claim* or the *paper Form CMS-1450.*

- Professional claim means any claim submitted using the HIPAA mandated transaction ASC X12 837 professional *claim* or the CMS-1500 paper claim form.

02 - Formats for Submitting Claims to Medicare

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

02.1 - Electronic Submission Requirements

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

The Administrative Simplification Compliance Act (ASCA) requires that claims be submitted to Medicare electronically unless certain exceptions are met. In addition, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the Secretary of Health and Human Services adopt standards for conducting certain health care transactions electronically, among them claims and remittance

advices. Therefore, claims sent to Medicare must be sent on HIPAA-standard health care claim transactions unless certain exceptions are met.

These exceptions are described in Chapter 24 of this manual in Sections 90 through 90.5.4.

02.1.1 - HIPAA Standards for Claims

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

The standards adopted under HIPAA include both a transaction standard and an implementation guide. The following are the claims transactions and the implementation guides adopted as standards under HIPAA:

Standard Claim Transaction	***Short Reference***	***Implementation Guide***	***Type of Claim***
ASC X12 Health Care Claim: Professional (837)	*ASC X12 837 professional claim*	*ASC X12 Standards for Electronic Data Interchange Technical Report Type 3— Health Care Claim: Professional (837)*	*Professional services and supplies, including retail pharmacy*
ASC X12 Health Care Claim: Institutional (837)	*ASC X12 837 institutional claim*	*ASC X12 Standards for Electronic Data Interchange Technical Report Type 3— Health Care Claim: Institutional (837)*	*Institutional*
Telecommunication Standard, National Council for Prescription Drug Programs and equivalent Batch Standard, National Council for Prescription Drug Programs	*Depending upon context: NCPDP claim; NCPDP transaction; NCPDP batch transaction; NCPDP batch claim*	*Telecommunication Standard Implementation Guide and equivalent Batch Standard Implementation Guide, National Council for Prescription Drug Programs.*	*Retail pharmacy professional services and supplies; retail pharmacy drugs*

Claims sent electronically to Medicare must abide by the HIPAA standards listed above. The current versions of these HIPAA standards are listed in chapter 24 of this manual. More information about HIPAA can be found at www.cms.gov, under the "Regulations and Guidance" tab. More information about these transactions and implementation guides can be found, as appropriate, at www.X12.org and www.NCPDP.org.

In addition, chapter 24 of this manual provides more information regarding Medicare's requirements for electronic data interchange (EDI), such as EDI enrollment and trading partner agreements.

Note that HIPAA standard implementation guides provide comprehensive directions regarding how to submit a claim on the transactions they support. Therefore, there is no separate guidance in this claim processing manual as to how to submit a claim using these transactions. However, there may be situations where the Medicare requirements require additional clarification, description, or guidance. In such cases, there will be additional instructions in the appropriate subject area section.

02.1.2 - Where to Purchase HIPAA Standard Implementation Guides

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

ASC X12 implementation guides (technical report 3s) may be purchased from the Washington Publishing Company (www.wpc-edi.com). NCPDP implementation guides may be purchased from the NCPDP at www.NCPDP.org

02.2 - Paper Claims

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

The ASCA law allows for there to be exceptions for which a provider, or other claim submitter, is permitted to send his/her claims to Medicare on paper. Refer to Chapter 24 §§90-90.5.4 for more information regarding ASCA exceptions.

02.2.1 - Paper Formats for Institutional Claims

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

The required format for submitting institutional claims to Medicare on paper is the CMS- 1450 form. Refer to chapter 25 for more information, including how to complete this form. In addition, where needed, additional instruction is provided throughout this manual for submitting paper claims.

02.2.2 - Paper Formats for Professional and Supplier Claims

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

The required format for submitting professional and supplier claims to Medicare on paper is the CMS-1500 claim form. Refer to chapter 26 for more information, including how to complete this form. In addition, where needed, additional instruction is provided throughout this manual for submitting paper claims.

02.3 - Remittance Advices

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

Another of the electronic health care transactions for which HIPAA requires the Secretary to adopt a standard is the remittance advice. The standard adopted is the ASC X12 Health Care Claim Payment/Advice (835). The current HIPAA version, including the implementation guide, is listed in Chapter 24. Throughout this manual, you may see references to this standard's short form, "ASC X12 835 remittance advice." More information about this transaction and its implementation guide can be found in chapters 22 and 24.

10.1.1 - Payment Jurisdiction Among *A/B MACs (B)* for Services Paid Under the Physician Fee Schedule and Anesthesia Services

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the ZIP code. Though a number of additional services appear on the MPFS database, these payment jurisdiction rules apply only to those services actually paid under the MPFS and to anesthesia services. (For example, it does not apply to clinical lab, ambulance or drug claims.)

Effective for claims received on or after April 1, 2004, *A/B MACs (B)* must use the ZIP code of the location where the service was rendered to determine *A/B MACs (B)* jurisdiction over the claim and the correct payment locality. Effective for dates of service on or after October 1, 2007, except for services provided in POS "Home," if they are not already doing so, *A/B MACs (B)* shall use the CMS ZIP code file along with

the ZIP code submitted on the claim with the address that represents where the service was performed to determine the correct payment locality. (See section 10.1.1B for instructions on processing services rendered in POS Home -12 and section 10.1.1.1 for instructions on when a 9-digit ZIP code is required.)

When a physician, practitioner, or supplier furnishes physician fee schedule or anesthesia services in payment localities that span more than one *A/B MAC (B)*'s service area (e.g., provider has separate offices in multiple localities and/or multiple *A/B MACs (B)*), separate claims must be submitted to the appropriate area *A/B MACs (B)* for processing. For example, when a physician with an office in Illinois furnishes services outside the office setting (e.g., home, hospital, SNF visits) and that out-of-office service location is in another *A/B MAC (B)*'s service area (e.g., Indiana), the *A/B MAC (B)* which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the *A/B MAC (B)* with the correct physician fee schedule pricing data for the location where the service was furnished. In the majority of cases, the physician fee schedule or anesthesia services provided by physicians are within the same *A/B MAC (B)* jurisdiction that the physicians' office(s) is/are located.

Although pricing rules for services paid under the MPFS remain in effect, effective for claims with dates of service on or after January 25, 2005, suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) must bill their *A/B MAC (B)* for the technical component (TC) and professional component (PC) of diagnostic tests that are subject to the anti-markup payment limitation, regardless of the location where the service was furnished. Beginning in 2005, and in each subsequent calendar year (CY) thereafter, CMS will provide *A/B MACs (B)* with a national abstract file containing Healthcare Common Procedural Coding System (HCPCS) codes that are payable under the MPFS as anti-markup tests for the year. In addition, CMS will make quarterly updates to the abstract file to add and/or delete codes, as needed, in conjunction with the MPFSDB quarterly updates. As with all other services payable under the MPFS, the ZIP code of the locality in which the service was furnished determines the payment amount. Refer to §30.2.9 of this chapter for information on the anti-markup payment limitation as it applies to supplier billing requirements.

A. Multiple Offices

In states with multiple physician fee schedule pricing localities or where a provider has multiple offices located in two or more states, or there is more than one *A/B MAC (B)* servicing a particular state, physicians, suppliers and group practices with multiple offices in such areas must identify the specific location where office-based services were performed. This is to insure correct claim processing jurisdiction and/or correct pricing of MPFS and anesthesia services. The *A/B MAC (B)* must ensure that multiple office situations are cross-referenced within its system. If a physician/group with offices in more than one MPFS pricing locality or a multi-contractor state fails to specify the location where an office-based service was furnished, the *A/B MAC (B)* will return/reject the claim as unprocessable.

Physicians, suppliers, and group practices that furnish physician fee schedule services at more than one office/practice location may submit their claims through one office to the *A/B MAC (B)* for processing. However, the specific location where the services were furnished must be entered on the claim so the *A/B MAC (B)* has the ZIP code, can determine the correct claims processing jurisdiction, and can apply the correct physician fee schedule amount.

B. Service Provided at a Place of Service Other than Home-12 or Office-11

For claims submitted prior to April 1, 2004, in order to determine claims jurisdiction, Medicare approved charges, Medicare payment amounts, Medicare limiting charges and beneficiary liability, Part B fee-for-service claims for services furnished in other than in an office setting or a beneficiary's home must include information specifying where the service was provided.

Effective for claims received on or after April 1, 2004, claims for services furnished in all places of service other than a beneficiary's home must include information specifying where the service was provided. *A/B MACs (B)* must use the address on the beneficiary files when place of service (POS) is home - 12, or any

other mechanism currently in place to determine pricing locality when POS is home – 12. *A/B MACs (B)* shall take this same action for any other POS codes they currently treat as POS home.

Effective for claims processed on or after October 5, 2009, for services rendered in POS home -12, or for any other POS the contractor currently treats as POS home, when alerted by the shared system that a 9-digit ZIP code is required according to the CMS ZIP Code file, and a 9-digit ZIP code is not available on the beneficiary file, the contractor shall determine that ZIP code by using the United States Postal Service Web site. They shall use that ZIP code to determine the correct payment locality for the claim for pricing purposes.

A/B MACs (B) processing these claims shall take necessary steps to ensure that the claims for services rendered in the physical location for which they are the MAC are priced and processed correctly applying appropriate edits as necessary.

Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the *ASC* X12 837 *professional claim format*, submission of the complete address of where the service was performed *is* required regardless of where the service was performed. This information should be entered on the claim per the Implementation Guide for the *current* version. Contractors shall use that ZIP code to determine correct payment locality.

Effective January 1, 2011 for claims processed on or after January 1, 2011 on paper claims submitted on the CMS-1500 *form*, submission of the ZIP code of where the service was provided will also be required for all POS code and contractors shall use that ZIP code to determine correct payment locality.

Contractors shall make no changes for claims submitted on the 4010A1 format as they pertain to POS Home and determining pricing locality.

Contractors shall require the submission of the 9-digit ZIP code when required per the CMS ZIP Code file.

C. Outside *A/B MAC (B)* Jurisdiction

If *A/B MACs (B)* receive claims outside of their jurisdiction, they must follow resolution procedures in accordance with the instructions in 10.1.9. If they receive a significant volume or experiences repeated incidences of misdirected Medicare Physician Fee Schedule or anesthesia services from a particular provider, an educational contact may be warranted.

D. HMO Claims

For services that HMOs are not required to furnish, *A/B MACs (B)* process claims for items or services provided to an HMO member over which they have jurisdiction in the same manner as they process other Part B claims for items or services provided by physicians or suppliers. Generally, the physician/supplier who provides in-plan services to its HMO members submits a bill directly to the HMO for payment and normally does not get involved in processing the claim. However, in some cases, claims for services to HMO members are also submitted to *A/B MACs (B)*, e.g., where claims are received from physicians for dialysis and related services provided through a related dialysis facility.

10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction

***(Rev. 3086, Issued: 10-03-14, Effective:* ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

A. Instructions for the 4010/4010A1 Version of the AS*C* X12 837 P*rofesional* Electronic Claim *(for Claims Processed Before Implementation of Version 5010)*

Note that the following instructions do not apply to services rendered at POS home -12. For services rendered at POS home – 12, use the address on the beneficiary file for the beneficiary's home (or wherever

else the beneficiary information is currently being stored) to determine pricing locality. *(*See §10.1.1 for changes to processing for services rendered at POS home – 12.)

For pricing purpose, contractors shall use the ZIP code of where the service was performed. Contractors shall locate that information according to the Implementation Guide of the 4010/4010A1 version of the AS*C* X12 837 *professional claim format*.

EXCEPTION: For DMERC claims - Effective for claims received on or after 1/1/05, the Standard System shall not evaluate the 2010AA loop for a valid place of service. If there is no entry in the 2420C loop or the 2310D loop, the claim shall be returned as unprocessable.

- If the Pay-To Provider Name and Address loop 2010AB is not the same as the Billing Provider, both will be entered. If the Service Facility Location loop 2310D is not the same as the Billing Provider or the Pay-To Provider, the Service Facility Location loop 2310D (claim level) will be entered. Price the service based on the ZIP code in Service Facility Location loop 2310D, unless the 2420C (line level) is also entered. In that case, price the service based on the ZIP code in the Service Facility Location loop 2420C (line level) for that line.

If the POS code is the same for all services, but the services were provided at different addresses, each service shall be submitted with the appropriate address information for each service. This will provide a ZIP code to price each service on the claim.

B. Entering the Address of Where a Service was Performed on the 5010 Version of the AS*C* X12 837 *Professional Claim*

Following the requirements of the *i*mplementation *g*uide of the 5010 version of the *ASC X12* 837*professional claim*, the complete address of where a service was performed shall be entered Pay the service based on the ZIP code of the address of where the service was performed based on the appropriate entry on the claim.

See §30.2.9 and Chapter 12 for information on purchased tests.

C. Paper Claims Submitted on the Form CMS-1500

Note that for claims processed on the Form CMS-1500 prior to January 1, 2011, the following instructions do not apply to services rendered at POS home – 12 or any other places of service contractors consider to be home. (See §10.1.1.1)

It is acceptable for claims to contain POS home and an additional POS code. No service address for POS home needs to be entered for the service rendered at POS home in this situation as the address will be drawn from the beneficiary file (or wherever else the *A/B MAC (B)* is currently storing the beneficiary information) and the information on the claim will apply to the other POS.

Except for the situation described above, the provider shall submit separate claims for each POS. The specific location where the services were furnished shall be entered on the claim. Use the ZIP code of the address entered in Item 32 to price the claim. If multiple POS codes are submitted on the same claim, treat the claim as unprocessable and follow the instructions in §80.3.1.

Use the following messages:

> Remittance Advice – Adjustment Reason Code 16 – "Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.)

Remark Code –M77 – "Missing/incomplete/invalid place of service."

MSN - 9.2 – "This item or service was denied because information required to make payment was missing."

Effective January 1, 2011, for claims processed on or after January 1, 2011, submitted on the Form CMS-1500 paper claim, it will no longer be acceptable for the claim to have more than one POS. Separate claims must be submitted for each POS. Contractors shall treat claims submitted with more than one POS as unprocessable and follow the instructions in §80.3.2.1.1.

If the contractor receives a fee-for-service claim containing one or more services for which the MPFS payment locality is in another *A/B MAC (B)*'s jurisdiction, handle in accordance with the instructions in §10.1.9. If you receive a significant volume or experience repeated incidences of misdirected Medicare Physician Fee Schedule claims/services from a particular provider, an educational contact may be warranted. Handle misdirected claims/services for HMO enrollees in accordance with §10.1.1.C and D.

D. Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services When Rendered in a Payment Locality that Crosses ZIP Code Areas

Per the instructions above, Medicare *A/B MACs (B)* have been directed to determine the payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. It has come to the attention of CMS that some ZIP codes fall into more than one payment locality. The CMS ZIP Code file uses the convention of the United States Postal Service, which assigns these ZIP codes into dominant counties. In some cases, though the service may actually be rendered in one county, per the ZIP code it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount. Note that as the services on the Purchased Diagnostic Test Abstract file are payable under the MPFS, the 9-digit ZIP code requirements will also apply to those codes.

Effective for dates of service on or after October 1, 2007, CMS shall provide a list of the ZIP codes that cross localities as well as provide quarterly updates when necessary. The CMS ZIP Code file shall be revised to two files: one for 5-digit ZIP codes (ZIP5) and one for 9-digit ZIP codes (ZIP9). Providers performing services paid under the MPFS, anesthesia services, or any other services as described above, in those ZIP codes that cross payment localities shall be required to submit the 9-digit ZIP codes on the claim for where the service was rendered. Claims for services payable under the MPFS and anesthesia services that are NOT performed in one of the ZIP code areas that cross localities may continue to be submitted with 5-digit ZIP codes. Claims for services other than those payable under the MPFS or anesthesia services may continue to be submitted with 5-digit ZIP codes.

Beginning in 2009, contractors shall maintain separate ZIP code files for each year which will be updated on a quarterly basis. Claims shall be processed using the correct ZIP code file based on the date of service submitted on the claim.

It should be noted that though some states consist of a single pricing locality, ZIP codes can overlap states thus necessitating the submission of the 9-digit ZIP code in order to allow the process to identify the correct pricing locality.

Claims received with a 5-digit ZIP code that is one of the ZIP codes that cross localities and therefore requires a 9-digit ZIP code to be processed shall be treated as unprocessable.

For claims received that require a 9-digit ZIP code with a 4-digit extension that does not match a 4-digit extension on file, manually verify the 4-digit extension to identify a potential coding error on the claim or a new 4-digit extension established by the U.S. Postal Service (USPS). ZIP code and county information may be found at the USPS Web site at http://www.usps.com/, or other commercially available sources of ZIP

code information may be consulted. If this process validates the ZIP code, the claim may be processed. The "Revision to Payment Policies Under the Physician Fee Schedule" that is published annually in the Federal Register, or any other available resource, may be used to determine the appropriate payment locality for the ZIP code with the new 4-digit extension. If this process does not validate the ZIP code, the claim shall be treated as unprocessable.

The following Remittance Advice and Remark Code messages shall be returned for the unprocessable claims:

> Adjustment Reason Code 16 – Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code or Remittance Advice Remark Code that is not an ALERT.)

Additional information is supplied using remittance advice remark codes whenever appropriate.

Remark Code MA 130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Submit a new claim with the complete/correct information.

Remark Code MA114 – Missing/incomplete/invalid information on where the services were furnished.

Should a service be performed in a ZIP code area that does not require the submission of the 9-digit ZIP code, but the 4-digit extension has been included anyway, *A/B MACs (B)* shall price the claim using the *A/B MAC (B)* locality on the ZIP5 file and ignore the 4-digit extension.

Effective for claims processed on or after July 6, 2009, the standard system shall make revisions to allow contractors to add valid 4-digit extensions not included on the current quarter's 9-digit ZIP Code file until they appear on a quarterly file.

Contractors shall reprocess claims brought to their attention if the next CMS quarterly file is received and the locality determination on a new 4-digit extension is different than that made manually by the contractor thus having inadvertently caused incorrect payment.

E. ZIP9 Code to Locality Record Layout

Below is the ZIP9 Code to locality file layout. Information on the naming conventions, availability, how to download the ZIP5 and ZIP9 files, and the ZIP5 layout can be found in Pub. 100-04, Chapter 15, section 20.1.6.

ZIP9 Code to Locality Record Layout

(Effective for dates of service on or after October 1, 2007.)

Field Name	Beg. Position	End Position	Length	Comments
State	1	2	2	
ZIP Code	3	7	5	
A/B MAC (B)	8	12	5	
Pricing Locality	13	14	2	
Rural Indicator	15	15	1	Blank=urban R=rural B=super rural
Filler	16	20	5	

Field Name	Beg. Position	End Position	Length	Comments
Plus Four Flag	21	21	1	0=no+4 extension 1=+4 extension
Plus Four	22	25	4	

30.2.9 - Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation - Claims Submitted to A/B MACs *(B)*

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

A physician or other supplier may bill for the technical component (TC) and/or professional component (PC) of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to the billing physician or other supplier through common ownership or control), subject to an anti-markup payment limitation, if the diagnostic test is performed by a physician who does not "share a practice" with the billing physician or other supplier. (This claim and payment limitation does not apply to clinical diagnostic laboratory tests, which are paid under the Clinical Laboratory Fee Schedule.) Under the anti-markup payment limitation, payment to the billing physician or other supplier (less the deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the TC or PC of the diagnostic test may not exceed the lowest of the following amounts:

(1) The performing supplier's net charge to the billing physician or other supplier.* (With respect to the TC, the performing supplier is the physician who supervised the test, and with respect to the PC, the performing supplier is the physician who performed the PC.);

(2) The billing physician or other supplier's actual charge; and

(3) The fee schedule amount for the test that would be allowed if the performing supplier billed directly. (See section 10.1.1.2 for information on payment jurisdiction for services subject to the anti-markup payment limitation.)

* The net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier.

Exception to the Anti-markup Payment Limitation

If the performing physician is deemed to "share a practice" with the billing physician or other supplier (who ordered the test), the anti-markup payment limitation does not apply. A performing physician is considered to "share a practice" with the billing physician or other supplier if the performing physician furnishes "substantially all" (at least 75 percent) of his or her professional services through the billing physician or other supplier. The "substantially all" services requirement will be satisfied, if, at the time the billing physician or other supplier submits a claim for a service furnished by the performing physician, the billing physician or other supplier has a reasonable belief that: (1) for the 12 months prior to and including the month in which the service was performed, the performing physician furnished substantially all of his or her professional services through the billing physician or other supplier; or (2) the performing physician will furnish substantially all of his or her professional services through the billing physician or other supplier for the next 12 months (including the month in which the service is performed).

If the performing physician does not meet the "substantially all" services test, the performing physician may be deemed to "share a practice" with the billing physician or other supplier if the arrangement complies with a "site of service/same building" test. This alternative approach requires the performing physician to be an owner, employer, or independent contractor of the billing physician or other supplier and requires that the TC or PC be performed "in the office of the billing physician or other supplier." The "office of the billing physician or other supplier" is any medical office space, regardless of the number of locations, in which the

ordering physician or other supplier regularly furnishes patient care, and includes space where the billing physician or other supplier furnishes diagnostic testing services, if the space is located in the "same building" (as defined in 42 CFR §411.351 of the physician self-referral rules) in which the ordering physician or other ordering supplier regularly furnishes patient care. With respect to a billing physician or other supplier that is a physician organization (as defined in 42 CFR §411.351 of the physician self-referral rules), the "office of the billing physician or other supplier" is space in which the ordering physician provides substantially the full range of patient care services the ordering physician provides generally. The performance of the TC includes, both, the conducting of the TC as well as the supervision of the TC.

The billing physician or other supplier must keep on file the name, the National Provider Identifier, and address of the performing physician. The physician or other supplier furnishing the TC or PC of the diagnostic test must be enrolled in the Medicare program. No formal reassignment is necessary.

NOTE: When billing for the TC or PC of a diagnostic test (other than a clinical diagnostic laboratory test) that is performed by another physician, the billing entity must indicate the name, address and NPI of the performing physician in Item 32 of the Form CMS-1500 claim form. However, if the performing physician is enrolled with a different *A/B MAC (B)*, the NPI of the performing physician is not reported on the Form CMS-1500 claim form. In this instance, the billing entity must submit its own NPI with the name, address, and ZIP code of the performing physician in Item 32 of the Form CMS-1500, or electronic equivalent, claim form. The billing supplier should maintain a record of the performing physician's NPI in the clinical record for auditing purposes.

If the billing physician or other supplier performs only the TC or the PC and wants to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically (ASC X12 837 *professional claim*) or on separate claims if billing on paper (Form CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

Effective for claims received on or after April 1, 2004:

In order to have appropriate service facility location ZIP code and the acquired price of each test on the claim, when billing for anti-markup tests on the CMS-1500 paper claim form each test must be submitted on a separate claim form. Treat paper claims submitted with more than one anti-markup test as unprocessable per §80.3.2.

More than one anti-markup test may be billed on the AS*C* X12 837 *professional claim* format. When more than one test is billed, the total acquired amount must be submitted for each service. Treat claims received with multiple anti-markup tests without line level total acquired amount information as unprocessable per §80.3.2.

Treat paper claims submitted for anti-markup tests with both the technical component (TC) and the professional component (PC) on one claim as unprocessable per §80.3.2 unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and the date of service and place of service codes match, assume that the one address in Item 32 applies to both services. Effective for claims with dates of service on or after April 1, 2005, each component of the test must be submitted on a separate claim form. Treat paper claims with dates of service after March 31, 2005 submitted with more than one anti-markup test as unprocessable per §80.3.2.

AS*C* X12 837 *professional* electronic claims submitted for anti-markup tests with both the TC and the PC on the same claim must be accepted. Assume that the claim level service facility location information applies to both services if line level information is not provided.

In order to price claims correctly and apply anti-markup payment limitations, global billing is not acceptable for claims received on the Form CMS-1500 or on the AS*C* X12 837 *professional claim* format. Each component must be billed as a separate line item (or on a separate claim per the limitations described

above). Treat the claim as unprocessable per §80.3.2 when a global billing is received and there is information on the claim that indicates the test was acquired.

Effective for claims with dates of service on or after January 25, 2005, A/B MACs *(B)* must accept and process claims for diagnostic tests subject to the anti-markup payment limitation when billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the A/B MAC *(B)*'s jurisdiction, regardless of the location where the service was furnished. Effective April 1, 2005, *A/B MACs (B)* must price anti-markup test claims based on the ZIP code of the location where the service was rendered when billed by a laboratory or an IDTF, using a CMS-supplied national abstract file of the MPFS containing the HCPCS codes that are payable under the MPFS as either a TC or PC of a diagnostic test subject to the anti-markup payment limitation for the calendar year. Effective for claims with dates of service on or after October 1, 2007, A/B MACs must use the national abstract file to price all claims for diagnostic tests subject to an anti-markup payment limitation, for all supplier specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the A/B MAC*(B)* jurisdictional pricing rules specified in §10.1.1. (See IOM Publication 100-04, Chapter 23, §30.6, and Addendum for record layouts and instructions for downloading the Abstract File for Diagnostic Tests Subject to the Anti-Markup Payment Limitation.)

NOTE: As with all services payable under the MPFS, the ZIP code is used to determine the appropriate payment locality and corresponding fee for the anti-markup test. When a ZIP code crosses locality lines, CMS uses the dominant locality to determine the corresponding fee.

30.2.13 - Billing Procedures for Entities Qualified to Receive Payment on Basis of Reassignment - for *A/B MAC (B)* Processed Claims

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

Except where otherwise noted, the following procedures apply to both assigned and unassigned claims submitted by medical groups and other entities entitled to bill and receive payment for physician services under §§30.2-30.2.8. They are used whether the charges are compensation related or non-compensation related.

A General

Chapter 26 contains general claims processing instructions. A medical group, or other entity entitled to bill and receive payment for physician services uses the *current ASC X12 professional claim billing format or Form CMS-1500* to submit claims to Medicare *A/B MACs (B)*. A single claim form may contain services furnished to the same patient by different physicians associated with the same entity. The name and address of the entity is entered in block 33 of Form CMS-1500 or in the corresponding AS*C* X12 *837* location. For paper claims an authorized official of the entity signs in block 31. This official need not be a physician. For *electronic* claims a certification can be maintained on file. (See CMS EDI Web page (http://www.cms.hhs.gov/providers/edi/edi3.asp) for electronic billing formats.)

B Provider Identification Numbers

The entity's NPI, when required, is entered in block 33*a*. Each physician who performs services for a patient must be identified on *the* Form CMS-1500 *claim* in block 24J for the appropriate line item in accordance with instructions in the Medicare Program Integrity Manual. (When an entity bills for an independent substitute physician under a reciprocal or locum tenens billing arrangement, the performing physicians is the physician member of the entity for whom the substitute is providing services.)

C Payment Records

Where the charges by a hospital, medical group, or other entity differ depending on the individual treating physician, *A/B MACs (B)* transmit the performing physician's UPIN or NPI when required on the Common

Working File (CWF) claim record. Where the charges by a hospital, medical group, or other entity are uniform regardless of the individual performing physician, claims records are prepared by entity and entity identification numbers rather than by individual physician and individual physician identification numbers. Show code 70 as specialty code on claims records where such entity's physicians have mixed (more than one) specialties. Where all the physicians associated with such entity have the same specialty, the code used reflects the specialty, e.g., code 30 for a group of radiologists, code 11 for a group of internists.

D Outpatient Physical Therapy or Speech-Language Pathology Claims

Clinics that have been certified to provide outpatient physical therapy or speech-language pathology services to outpatients also use *the ASC X12 837 professional claim format, or the* CMS-1500 *claim form* for billing the *A/B MAC (B)*.

30.3.7 - Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) Subject to the Anti-Markup Payment Limitation - Claims Submitted to *A/B MACs (B)*

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

A. General

A physician or other supplier may bill and receive payment for the technical component (TC) or professional component (PC) of a diagnostic test (other than clinical diagnostic laboratory test) that is performed by a physician or other supplier with whom the billing physician or other supplier does not share a practice. Reimbursement for that service is subject to the anti-markup payment limitation. If a physician or other supplier's bill or a request for payment includes a charge for a diagnostic test (other than a clinical diagnostic laboratory test) which the physician or other supplier did not personally perform or supervise, then payment for the test may not exceed the lesser of:

- The performing physician's net charge to the billing physician or other supplier (net any discounts);
- The billing physician's actual charge; or
- The fee schedule amount that would be allowed for the test if the performing physician or other supplier billed directly.

(See §30.2.9 of this chapter for additional information.)

For payment to be made, the physician who acquires the TC or PC of a diagnostic test from an outside source must identify the performing physician or other supplier *on the claim.* (The billing physician or other supplier should maintain a record of the performing physician or other supplier's NPI in the clinical record for auditing purposes.)

The billing physician or other supplier must also indicate *on the claim* that the test is subject to the anti-markup payment limitation.

See the guidelines at http://www.wpc-edi.com/ for how to show this on electronic claims.

If using the CMS-1500 paper claim form:

- *In item 20 check "yes" to indicate the test is subject to the anti-markup payment limitation and enter the amount the performing physician or other supplier charged.*
- In item 32 *enter the name, address, and NPI of the performing physician or supplier*. If the performing physician provides the service outside the *A/B MAC (B)* jurisdiction where the billing

physician is located, the billing physician must submit its own NPI with the name, address, and ZIP code of the performing physician or other supplier.

No payment may be made to the physician without this information unless the statement "No anti-markup tests are included" is annotated on the claim.

NOTE: If the billing physician performs only the TC or the PC and wants to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically or on separate claims if billing on paper. Global billing is not allowed unless the billing physician or other supplier performs both components.

B. Unassigned Claims with Required Documentation

A physician or other supplier may not bill an individual an amount in excess of Medicare's payment, except for any deductible and coinsurance, for the TC or PC of a diagnostic test that is subject to the anti-markup payment limitation. *A/B MACs (B)* must notify physicians and other suppliers that they must indicate when a diagnostic test was acquired, identify the performing physician or other supplier, and show the amount the performing physician or other supplier charged. The notification must inform physician and other suppliers that they are prohibited by §1842(n)(3) of the Act from billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance. Excess amounts collected from the beneficiary must be repaid.

C. Unassigned Claims without Required Documentation

A physician may not bill a beneficiary:

- If the bill does not indicate who performed the test; and

- If the bill indicates that a separate physician or other supplier performed the test, it does not identify the performing physician or other supplier or does not include the amount the performing physician or other supplier charged.

The *A/B MACs (B)* notify the physician when a non-assigned claim for the TC or PC of a diagnostic test subject to the anti-markup payment limitation is received from either the physician or a beneficiary except when the physician submits an assigned claim and the beneficiary submits an unassigned duplicate claim. They use the following sample letter.

> Dear Doctor:
>
> We have received an unassigned claim for diagnostic tests furnished to the patient (Beneficiary Name), on (Date of Service). You are prohibited by §1842(n)(3) of the Social Security Act from billing or collecting any amount unless you indicate that "No anti-markup tests are included" or, if the diagnostic test was acquired, you indicate who performed the test and what the physician or other supplier charged you. Some or all of the required information is missing from your patient's claim. If you have collected any amount from your patient, it must be refunded. This claim may be resubmitted if the required information is included.

D. Beneficiary Information Regarding Unassigned Claims

The *A/B MACs (B)* must notify the beneficiary that the physician is prohibited from:

- Billing the beneficiary when the necessary documentation is not supplied; and

- Billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance, when the required documentation is submitted.

(See chapter 21, for MSN messages.)

50.1.1 - Billing Form as Request for Payment

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

Each of *the paper* billing forms--*CMS-1500*-- Health Insurance Claim Form; and *CMS-1490S-- Patient's* Request for Medicare Payment,)-- contains a patient's signature line or reference to the patient signature incorporating the patient's request for payment of benefits, authorization to release information, and assignment of benefits. When the billing form is used as the request for payment, there must be a signature, except when the provisions in §50.1.2 apply.

The Medicare Uniform Institutional Provider Bill, Form CMS-1450, does not contain a line for the patient's signature. As a result, the billing form itself cannot be used as a request for payment. Requests for payment must be obtained and retained in the provider's records. The institutional claim form contains a provider representative signature, which includes a certification that a request for payment has been obtained from the patient. See §50.1.2 for requirements for providers.

Electronic billing is required except when an exception is possible under ASCA. See §2 of this chapter for related information.

50.1.2 - Beneficiary Request for Payment on Provider Record - *ASC X12 837 Institutional Claims*

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

A participating provider (hospital, critical access hospital, skilled nursing facility, home health agency, outpatient physical therapy provider, or comprehensive outpatient rehabilitation facility), ESRD facility, Independent rural health clinic, freestanding Federally Qualified Health Clinic, Religious Nonmedical Health Care Institution, or Community Mental Health Centers must use a procedure under which the signature of the patient (or his representative) on its records will serve as a request for payment for services of the provider.

To implement this procedure the provider must incorporate language to the following effect in its records:

Request for Payment

_____ _____

NAME OF BENEFICIARY HI CLAIM NUMBER

I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by or in (name of provider). I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

For services furnished to inpatients of a hospital, or SNF, the request is effective for the period of confinement. For services furnished by an HHA under a plan of treatment the request is effective for the plan of treatment. For other services the request is effective until revoked. If a patient objects to part of the request for payment, the provider should annotate the statement accordingly.

In using this procedure, the provider undertakes to make the patient signature files available for *A/B MAC (A and B)* inspection on request.

The *A/B MAC (A and B)* must make periodic audits of signature files selected on a random basis. The *A/B MAC (B)* may arrange with the *A/B MAC (A)* for the latter to perform this function on its behalf for *A/B MAC (B)* claims submitted by providers.

50.1.7 - Definition of a Claim for Payment

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

For those billing *A/B MACs (B)* and DME *MACs*, a claim does not have to be on a form but may be any writing submitted by or on behalf of a claimant, which indicates a desire to claim payment from the Medicare program in connection with medical services of a specified nature furnished to an identified enrollee. It is not necessary that this submission be recorded on a CMS claim form, that the services be itemized or that the information submitted be complete (e.g., a note from the enrollee's spouse, or a bill for ancillary services in a nonparticipating hospital, could count as a claim for payment).

The writing must contain sufficient identifying information about the enrollee to permit the obtaining of any missing information through routine methods, e.g., file check, microfilm reference, mail or telephone contact based on an address or telephone number in file. Where the writing is not submitted on a claims form, there must be enough information about the nature of the medical or other health service to enable the contractor with claims processing jurisdiction to determine that the service was apparently furnished by a physician or supplier.

The definition of a part B claim for purposes of timely filing is any writing submitted by or on behalf of a claimant, which indicates a desire to claim payment from the Medicare program for medical services of a specified nature to an identified enrollee. For example, a note from the enrollee's spouse or a bill for ancillary services in a nonparticipating hospital could constitute a claim for payment.

If such a claim is mailed or delivered to SSA, CMS or to any *A/B MAC (A or B)* within the time limit, the claim is filed timely provided the necessary claims information (e.g., Form *CMS*-1490*S* and itemized bill in the case of an enrollee-filed claim) is submitted within the time limit or, if later, within six months after the end of the month in which the claimant is advised to furnish it, e.g., if the notice is provided February 2, the claim must be filed by close of business August 31. See Statement of Intent instructions in §70.7.

Note that electronic claims must be in *the appropriate HIPAA standard* format. *Refer to section 2 of this chapter as well as chapters 24 and 25 for more information*.

50.3.2 - Policy and Billing Instructions for Condition Code 44

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

In cases where a hospital or a CAH's UR committee determines that an inpatient admission does not meet the hospital's inpatient criteria, the hospital or CAH may change the beneficiary's status from inpatient to outpatient and submit an outpatient claim (bill type 13x or 85x) for medically necessary Medicare Part B services that were furnished to the beneficiary, provided all of the following conditions are met:

1. The change in patient status from inpatient to outpatient is made prior to discharge or release, while the beneficiary is still a patient of the hospital;

2. The hospital has not submitted a claim to Medicare for the inpatient admission;

3. The practitioner responsible for the care of the patient and the UR committee concur with the decision; and

4. The concurrence of the practitioner responsible for the care of the patient and the UR committee is documented in the patient's medical record.

While typically the full UR committee makes the decision for the committee that a change in patient status under Condition Code 44 is warranted, in accordance with §482.30(d)(1) one physician member of the UR committee may make the decision for the committee, provided he or she is a different person from the concurring practitioner who is responsible for the care of the patient.

When the hospital has determined that it may submit an outpatient claim according to the conditions described above, the entire episode of care should be billed as an outpatient episode of care on a 13x or 85x bill type and outpatient services that were ordered and furnished should be billed as appropriate.

Refer to Pub. 100-04, Medicare Claims Processing Manual; Chapter 30, Financial Liability Protections; Section 20, Limitation On Liability (LOL) Under §1879 Where Medicare Claims Are Disallowed, for information regarding financial liability protections.

When the hospital submits a 13x or 85x bill for services furnished to a beneficiary whose status was changed from inpatient to outpatient, the hospital is required to report Condition Code 44 on the outpatient claim in one of Form Locators 24-30, or in the AS*C* X12 837 *institutional claim* format in Loop 2300, HI segment, with qualifier BG, on the outpatient claim. Additional information may be found in Chapter 25 of this manual, (Completing and Processing the Form CMS-1450 Data Set). Condition Code 44 is used by CMS and QIOs to track and monitor these occurrences. The reporting of Condition Code 44 on a claim does not affect the amount of hospital outpatient payment that would otherwise be made for a hospital outpatient claim that did not require the reporting Condition Code 44.

One of the requirements for the use of Condition Code 44 is concurrence by the practitioner who is responsible for the care of the patient with the determination that an inpatient admission does not meet the hospital's admission criteria and that the patient should have been registered as an outpatient. This prerequisite for use of Condition Code 44 is consistent with the requirements in the CoP in §482.30 (d) of the regulations. This paragraph provides that the practitioner or practitioners responsible for the care of the patient must be consulted and allowed to present their views before the UR committee or QIO makes its determination that an admission is not medically necessary. It may also be appropriate to include the practitioner who admitted the patient if this is a different person than the practitioner responsible for the care of the patient.

If the conditions for use of Condition Code 44 are not met, the hospital may submit a 12x bill type for covered "Part B Only" services that were furnished to the inpatient. Medicare may still make payment for certain Part B services furnished to an inpatient of a hospital when payment cannot be made under Part A because an inpatient admission is determined not to be medically necessary. Information about "Part B Only" services is located in Pub. 100-02, Medicare Benefit Policy Manual, chapter 6, section 10. Examples of such services include, but are not limited to, diagnostic x-ray tests, diagnostic laboratory tests, surgical dressings and splints, prosthetic devices, and certain other services. The Medicare Benefit Policy Manual includes a complete list of the payable "Part B Only" services. See Pub. 100-04, Medicare Claims Processing Manual, chapter 4, section 10.12 for a discussion of the billing and payment rules regarding services furnished within the payment window for outpatient services treated as inpatient services.

Entries in the medical record cannot be expunged or deleted and must be retained in their original form. Therefore, all orders and all entries related to the inpatient admission must be retained in the record in their original form. If a patient's status changes in accordance with the requirements for use of Condition Code 44, the change must be fully documented in the medical record, complete with orders and notes that indicate why the change was made, the care that was furnished to the beneficiary, and the participants in making the decision to change the patient's status.

When Condition Code 44 is appropriately used, the hospital reports on the outpatient bill the services that were ordered and provided to the patient for the entire patient encounter. However, in accordance with the general Medicare requirements for services furnished to beneficiaries and billed to Medicare, even in Condition Code 44 situations, hospitals may not report observation services using HCPCS code G0378 (Hospital observation service, per hour) for observation services furnished during a hospital encounter prior to a physician's order for observation services. Medicare does not permit retroactive orders or the inference of physician orders. Like all hospital outpatient services, observation services must be ordered by a physician. The clock time begins at the time that observation services are initiated in accordance with a physician's order.

While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met. On the outpatient claim on an uncoded line with revenue code 0762, the hospital could bill for the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services. For other rules related to billing and payment of observation services, see chapter 4, section 290 of this manual, and Pub.100-02, Medicare Benefit Policy Manual, chapter 6, Section 20.6.

60.1 - General Information on Non-covered Charges on Institutional Claims

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

Charges are tied to items or services described by coding on a line of a claim where they appear together. The institutional claim formats (the *ASC* X12 837 *institutional* claim transaction and the Form CMS-1450 paper claim) provide separate fields for the submission of total charges and non-covered charges.

When billing, claims submitters make a choice between submitting charges as covered, or as non-covered. When total charges are submitted and non-covered charges are not submitted, the charges for the claim line are submitted as covered. When a claim line is submitted with covered charges, the provider is seeking payment for that line.

When total charges and non-covered charges submitted on a claim line are equal, the charges for that claim line are submitted as non-covered. When a claim line is submitted with non-covered charges, the provider is not seeking payment for that line and the line is denied payment by Medicare systems. Therefore, Medicare accepts any National Uniform Billing Committee-approved revenue codes when they are submitted with non-covered charges, without regard to whether these revenue codes would be valid for Medicare billing if submitted seeking payment.

Lines submitted with covered and non-covered charges can appear together on a single Medicare claim. In rare instances, covered and non-covered charges can appear on the same line. In these cases, the total charge amount is greater than the non-covered charge amount on the line.

Even when Medicare payment is not requested, there can be Medicare notice requirements that establish financial liability between beneficiaries and their providers. These liability notices, such as Advance Beneficiary Notices of Noncoverage (ABNs), serve to ensure that providers can shift the financial liability for items and services to their Medicare patients, consistent with §1862(a)(1) and §1879 of the Social Security Act (i.e., the Act). See Chapter 30 of this manual for more information on financial liability and related notices.

NOTE: In this section, the term 'provider' may include institutional providers or suppliers and other comparable entities delivering medical items and services billed on institutional claims.

This statutory ability to shift liability only applies when billing items and services usually covered as part of established Medicare benefits. These benefits are described in law, in Title XVIII of the Act, which authorizes the Medicare Program. Other benefits not addressed in Title XVIII are known as being "statutorily excluded," meaning Medicare is not authorized to pay for them under the Act.

Financial liability for an item or service that could be a Medicare benefit is codified in statute, along with the benefits themselves. Liability occurs when such items or services are thought to be non-covered by the Program for specific reasons also given in the Act:

- §1862(a)(1) on services that otherwise could be covered but which are not medically reasonable and necessary in the individual case at hand,
- §1862(a)(9) for custodial care which Medicare never covers,
- §1879(g)(1) for home care given to a beneficiary who is neither homebound nor needs intermittent skilled services at home, or lastly, under
- §1879(g)(2) for hospice care given to someone not terminally ill.

When one of these stipulated reasons will apply to a denial on an Original Medicare claim, the reason has to appear on a notice given in advance of delivery of services, and before preparation of a related claim. These notices, like an ABN, give a level of detail that allows the involved beneficiary to understand why no coverage is likely to occur in that specific circumstance.

The financial liability that remains when Medicare does not pay belongs to either providers or beneficiaries. Such determinations are made by Medicare when processing related claims. Sometimes, providers and beneficiaries make their own agreements on payment without billing Medicare, which Medicare allows them to do. More often, Medicare is billed, since resulting denials of claims, even when submitted with non-covered charges, have appeal rights under Medicare over payment. See Chapter 29 of this manual for more information on such appeals.

Appeals rights are not expected to be used for non-covered charges, certainly not with any frequency. When no amounts are in dispute since no payment is sought, appeals tend not to occur. Charges submitted as non-covered should indicate that there is an understanding shared by the involved beneficiary and provider that Medicare payment is not expected. For example, non-covered charges could be used for cosmetic surgery because both parties know this surgery is never a Medicare benefit, or statutorily excluded. The surgery may be billed to Medicare so that subsequent payers could see a Medicare denial when they require proof of denials by payers more primary in the sequence of coverage.

Claims which are rejected by the Medicare contractor or are returned to the provider (or RTP'ed) can be corrected and re-submitted, permitting a payment determination to be made after resubmission. In some cases, beneficiaries may appeal rejections, but they can NEVER appeal RTP'ed claims. Rejections may be apparent on remittances for claims submitted with administrative errors, but beneficiaries cannot be held liable for items and services that were never properly billed to Medicare.

In contrast, denied claims can never be resubmitted, since they are in fact the result of official payment determinations made by Medicare. As mentioned, such determinations can be appealed.

70.2.2 - Form Prescribed by CMS

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

Refer to section 2 for the acceptable claim formats. As noted in section 2, ASCA law requires that claims sent to Medicare be sent electronically unless an exception is met. Claims submitted on paper forms are entered into Medicare's electronic claims processing system and converted into electronic records in order to be processed. After the point of entry into the electronic system, handling of claims submitted on the prescribed electronic format and on its paper equivalent is identical with regard to determining timely filing. *Regulations at 42 CFR 424.32 (b) prescribe the claim forms to be used for a paper claim submission.*

70.2.3 - In Accordance with CMS Instructions

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

The CMS instructions for submitting institutional claims to Medicare are contained in this manual. General instructions that reflect guidance on *reporting institutional claim data* are found in Chapter 25. These instructions apply to all institutional claim types, whether *paper or electronic*. Additional chapters in this manual supplement these general instructions. For example, see instructions for inpatient hospital billing in Chapter 3, or inpatient skilled nursing billing in Chapter 6. *General information about billing for physician and other supplier services and about the CMS 1500 claim form can be found in Chapter 26,* Completing and Processing Form CMS-1500 Data Set, *as well as chapters throughout this manual relative to specific policies and topics. For example see Chapter 12, Physicians/Nonphysician Practitioners, Chapter 13, Radiology Services and Other Diagnostic Services, or Chapter 16, Laboratory Services for detailed instructions for specific services.*

In order to constitute a Medicare claim, *services submitted for payment must be submitted to the appropriate Medicare contractor (§70.2.1), in a proper claim format (§70.2.2)*, and in accordance with *these CMS* claim completion instructions. Services submitted for payment in a manner not complete and consistent according to these instructions will not be accepted into Medicare's electronic claims processing system and will not be considered filed for purposes of determining timely filing.

70.2.3.2 - Handling Incomplete or Invalid Submissions

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

The *A/B MACs (A)* should take the following actions upon receipt of incomplete or invalid submissions:

- If a required data element is not accurately entered in the appropriate field, RTP the submission to the provider of service.

- If a not required data element is accurately or inaccurately entered in the appropriate field, but the required data elements are entered accurately and appropriately, process the submission.

- If a conditional data element (a data element which is required when certain conditions exist) is not accurately entered in the appropriate field, RTP the submission to the provider of service.

- If a submission is RTP for incomplete or invalid information, at a minimum, notify the provider of service of the following information:

    - Beneficiary's Name;
    - Health Insurance Claim (HIC) Number;

- Statement Covers Period (From-Through);
- Patient Control Number (only if submitted);
- Medical Record Number (only if submitted); and
- Explanation of Errors.

NOTE: Some of the information listed above may in fact be the information missing from the submission. If this occurs, the *A/B MAC (A)* includes what is available.

- If a submission is RTP for incomplete or invalid information, the *A/B MAC (A)* shall not report the submission on the MSN to the beneficiary. The notice must only be given to the provider or supplier.

Refer to the implementation guide for the current *ASC X12 837 institutional claim* format for specifications. If a claim fails edits for any one of the content or size requirements, the *A/B MAC (A)* will RTP the submission to the provider of service.

NOTE: The data element requirements in the *implementation guide* may be superseded by subsequent CMS instructions. The CMS is continuously revising instructions to accommodate new data element requirements.

The *A/B MACs (A)* must provide a listing of the *required data elements*, *including* a brief explanation to providers and suppliers. *A/B MACs (A)* must educate providers regarding the distinction between submissions which are not considered claims, but which are returned to provider (RTP) and submissions which are accepted by Medicare as claims for processing but are not paid. Claims may be accepted as filed by Medicare systems but may be rejected or denied. Unlike RTPs, rejections and denials are reflected on RAs. Denials are subject to appeal, since a denial is a payment determination. Rejections may be corrected and re-submitted.

70.8.4 - Claims Forms *CMS-1490S and CMS-1500*

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

A number of prescribed claims forms have been developed for use when requesting payment for Part B Medicare services. Many are printed and distributed nationally free of cost through CMS's Printing and Publications Branch. (See NOTE below for exception.)

In order to maintain control over the content and format of the forms, private printing of a Government form is not routinely permitted. However, if you or another organization wishes to independently print a prescribed claims form, the reproduction of a claims form must be in accordance with §422.527 of Title 20, Chapter III, Part 422 of the Code of Federal Regulations. Obtain CMS approval for printing a prescribed form. Route the written request for approval through the RO. Include the following:

- The reason or need for such reproduction;
- The intended user of the form;
- The proposed modifications or format changes, with printing or other specifications (such as realignment of data or line designations);
- The type of automatic data processing machinery, if any, for which the form is designed; and

- Estimates of printing quantity, cost per thousand, and annual usage.

NOTE: This procedure does not apply to the Form CMS-1500, Health Insurance Claim Form. *A/B MACs (B)*, physicians and suppliers are responsible for purchasing their own forms. This form can be bought in single, multipart snap-out sets or in continuous pin-feed format. Medicare accepts any version. Forms can be obtained from local printers or printed in-house as long as it follows the CMS approved specifications developed by the *National Uniform Claim Committee*.

The Form CMS-l490 was formerly the basic Part B claims form. It was replaced by Form CMS-l500 for claims completed by physicians and suppliers (except ambulance suppliers), and Form CMS-l490S for claims from beneficiaries. You must, however, continue to accept and process claims received on Form CMS-1490 form after conversion to Forms CMS-l500 and CMS-l490S.

The Form CMS-1500 (Health Insurance Claim Form) is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance services), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc.

The forms described below are printed and distributed to contractors by CMS and are available in single sheets, multipart snap-out sets, or in pin-feed format.

The Form CMS-1490S (Patient's Request for Medicare Payment) form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains only the first six comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Social Security Offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims. For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so. Inasmuch as the Form CMS-1490S has no provision for a *diagnosis* code, the *diagnosis* code is not required at the time of claim submission.

The Form CMS-1556 (Prepayment Plan for Group Practices Dealing Through A*n A/B MAC (B)*) is used by plans which, for Medicare purposes are, both Group Practice Prepayment Plans, and are paid on the basis of reasonable charges related to their costs for furnishing services to their subscribers.

80.3.2.1.2 - Conditional Data Element Requirements for A/B MACs *(B)* and DME MACs

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

A - Universal Requirements

The following instruction describes “conditional” data element requirements, which are applicable to certain assigned A/B MAC *(B)* claims. This instruction is minimal and does not include all “conditional” data element requirements, which are universal for processing claims. The CMS has specified which remark code(s) should be used when a claim fails a particular “return as unprocessable” edit and a remittance advice is used to return the claim. In addition to the specified remark code(s), A/B MACs *(B)* must include Remark Code MA130 on returned claim(s). Reason code(s) must also be reported on every remittance advice used to return a claim or part of a claim as unprocessable.

Items from the Form CMS-1500 *claim form* have been provided. These items are referred to as fields in the instruction.

A/B MACs *(B)* processing claims on the Form CMS-1500 must return a claim as unprocessable to the supplier/provider of service in the following circumstances:

1. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified in Claim Specific Requirements) and his/her name is not present in item 17 or if the NPI is not entered in item 17b of the Form CMS-1500. (Remark code N285 or N286 is used)

2. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or NPI required of the supervising physician is not entered in items 17 or if the NPI is not entered in item 17b of the Form CMS-1500. (Remark code N269 or N270 is used.)

   NOTE: For item 80.3.2.1.2. - 1. above, effective for claims with dates of service (DOS) on or after the implementation date of the Phase 2 ordering and referring denial edits, if the Part B clinical lab and imaging technical or global component claim or Durable Medical Equipment, Prosthetics, and Orthotics Suppliers (DMEPOS) claim is denied due to the ordering/referring provider not allowed to order/refer, contractors shall use Group Code CO, Claim Adjustment Reason Code (CARC) 183 and Remittance Advice Remark Codes (RARCs) N574 and MA13 when denying such claims. If the claim is denied due to the ordering/referring provider's name not matching (i.e., the first four letters of the last name provided on the claim don't match what's listed in the provider's record), contractors shall use Group Code CO, CARC 16, RARCs N264 and N575 and MA13.

   If a claim is submitted that lists an ordering/referring provider and the required matching NPI is not reported, then the claim shall be rejected using Group Code CO, CARC 16, RARCs N265 and MA13. This is the only instance when a rejection is allowed.

3. For the technical component (TC) and professional component (PC) of diagnostic tests subject to the anti-markup payment limitation:

   a. If a "YES" or "NO" is not indicated in item 20 and no acquisition price is entered under the word "$CHARGES." A/B MACs *(B)* shall assume the service is not subject to the anti-markup payment limitation. This claim shall not be returned as unprocessable for this reason only.

   b. If a "Yes" or "No" is not indicated in item 20 and an acquisition price is entered under the word "$CHARGES." (Remark Code MA110 is used.)

   c. If the "YES" box is checked in item 20 and a required acquisition price is not entered under the word "$CHARGES." (Remark code MA111 is used.)

   d. If the "NO" box is checked in item 20 and an acquisition price is entered under the word "$CHARGES." (Remark code MA110 is used.)

   e. If the "YES" box is checked in item 20 and the acquisition price is entered under "$CHARGES", but the performing physician or other supplier's name, address, ZIP Code, and NPI is not entered into item 32a of the Form CMS-1500 when billing for diagnostic services subject to the anti-markup payment limitation. (Remark code N294 is used.)

   Entries f - j are effective for claims received on or after April 1, 2004:

f. On the Form CMS-1500, if the "YES" box is checked in Item 20, and more than one test is billed on the claim;

g. On the Form CMS-1500, if both the TC and PC are billed on the same claim and the dates of service and places of service do not match;

h. On the Form CMS-1500, if the "YES" box is checked in Item 20, both the TC and PC are submitted and the date of service and place of service codes do not match.

i. On the *ASC X12 837 professional claim* format, if there is an indication on the claim that a test is subject to the anti-markup payment limitation, more than one test is billed on the claim, and line level information for each total acquisition amount is not submitted for each test.

j. On the Form CMS-1500 if the "YES" box is checked in Item 20 and on the *ASC X12 837 professional claim* format if there is an indication on the claim that a test is subject to the anti-markup payment limitation, and the service is billed using a global code rather than having each component billed as a separate line item.

4. If a provider of service or supplier is required to submit a diagnosis in item 21 and either *the diagnosis* code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. (Remark code M81 or M76 are used.)

5. For claims received on or after April 1, 2013, if a provider of service or supplier is required to submit a diagnosis in Item 21 of the Form CMS- 1500 and an ICD-9-CM "E" code (external causes of injury and poisoning) is reported in the *first* field of Item 21. And, effective for dates of service on or after the effective date for ICD-10-CM codes, if an ICD-10-CM diagnosis code within the code range of V00 through Y99 is reported in the *first* field of Item 21. (Remark Code MA63 is used.)

   For paper claims, ICD-10-CM codes can be reported only on the revised CMS-1500 claim form version 02/12, but not before the effective date of ICD-10-CM. The revised form (02/12) has the capacity to accept either ICD-9-CM or ICD-10-CM codes depending upon the effective date of the ICD code set. The old form version (08/05) had only the capacity to accept ICD-9-CM codes. Refer to chapter 26 for more information about the old and revised forms).

6. If a rendering physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner who is a sole practitioner or is a member of a group practice does not enter his/her NPI into item 24J of Form CMS-1500 except for influenza virus and pneumococcal vaccine claims submitted on roster bills that do not require a rendering provider NPI. (Remark code N290 is used.)

7. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. (Remark code(s) MA64, MA88, MA89, or MA92 as appropriate for the missing piece(s) of data are used.)

8. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act number, but a Payer or Plan identification number (use *HPID* when effective) is not entered in field 11C, or the primary payer's

program or plan name when a Payer or Plan ID (use *HPID* when effective) does not exist. (Remark code MA92 or N245 is used.)

9. If a HCPCS code modifier must be associated with a HCPCS procedure code or if the HCPCS code modifier is invalid or obsolete. (Remark code M20 if there is a modifier but no HCPCS.)

10. If a date of service extends more than 1 day and a valid "to" date is not present in item 24A. (Remark code M59 is used.)

11. If an "unlisted procedure code" or a "not otherwise classified" (NOC) code is indicated in item 24D, but an accompanying narrative is not present in item 19 or on an attachment. (Remark code M51 is used.)

12. If the name, address, and ZIP Code of the facility where the service was furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office is not entered in item 32 (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered. (Remark code MA114 is used.)

    Effective for claims with dates of service on or after October 1, 2007, the name, address, and 9-digit ZIP Code of the service location for services paid under the Medicare Physician Fee Schedule and anesthesia services, other than those furnished in place of service home – 12, and any other places of service A/B MACs treat as home, must be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1. (Remark code MA114 is used.)

    Effective for claims with dates of service on or after October 1, 2007, for claims received that require a 9-digit ZIP Code with a 4 digit extension, a 4-digit extension that matches one of the ZIP9 file or a 4-digit extension that can be verified according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 must be entered on the claim. (Remark code MA114 is used.)

    Effective January 1, 2011 for claims processed on or after January 1, 2011 on the Form CMS-1500, the name, address, and 5 or 9-digit ZIP code, as appropriate, of the location where the service was performed for services paid under the Medicare Physician Fee Schedule and anesthesia services, shall be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 for services provided in all places of service. (Remark code MA114 is used.)

    Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the *ASC X12 837 professional* electronic claim form*at* for services payable under the MPFS and anesthesia services when rendered in POS home (or any POS they consider home) if submitted without the service facility location. (Remark code MA114 is used.)

13. Effective for claims received on or after April 1, 2004, if more than one name, address, and ZIP Code is entered on the Form CMS-1500 in item 32.

14. If any of the modifiers PA, PB, or PC are incorrectly associated with a service which is other than a wrong surgery on a patient, surgery on the wrong body part, surgery on the wrong patient or a service related to one of these surgical errors. (Claim Adjustment Reason Code 4 is used.)

80.3.2.1.3 – *A/B MAC (B)* Specific Requirements for Certain Specialties/Services

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

A/B MACs (B) must return the following claim as unprocessable to the provider of service/supplier:

A. For chiropractor claims:

1. If the x-ray date is not entered in item 19 for claims with dates of service prior to January 1, 2000. Entry of an x-ray date is not required for claims with dates of service on or after January 1, 2000.

2. If the initial date "actual" treatment occurred is not entered in item 14. (Remark code MA122 is used.)

B. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and the group's name, address, and ZIP Code is not entered in item 33 or if the NPI is not entered in item 33a of the Form CMS-1500, if their personal NPI is not entered in item 24J of the Form CMS-1500. (Remark code MA112 is used.)

C. For durable medical, orthotic, and prosthetic claims, if the name, address, and ZIP Code of the location where the order was accepted were not entered in item 32. (Remark code MA 114 is used.)

D. For physicians who maintain dialysis patients and receive a monthly capitation payment:

1. If the physician is a member of a professional corporation, similar group, or clinic, and the NPI is not entered in item 24J of the Form CMS-1500. (Remark code N290 is used.)

2. If the name, address, and ZIP Code of the facility other than the patient's home or physician's office involved with the patient's maintenance of care and training is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

E. For routine foot care claims, if the date the patient was last seen and the attending physician's NPI is not present in item 19. (Remark code N324 or N253 is used.)

F. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name is not present in items 17 or 17a or if the NPI is not entered in item 17b of the Form CMS-1500. (Remark code N264 or N286 is used.)

G. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his or her name is not present in items 17 or in 17a or if the NPI is not entered in item 17b of the Form CMS-1500. (Remark code N264 or N286 is used.)

H. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other the patient's home or physician's office (including services to a patient in an institution), if the name, address, and ZIP Code of the location where services were performed is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

I. For independent laboratory claims:

1. Involving EKG tracing and the procurement of specimen(s) from a patient at home or in an institution, if the claim does not contain a validation from the prescribing physician that any laboratory service(s)

performed were conducted at home or in an institution by entering the appropriate annotation in item 19 (i.e., “Homebound”). (Remark code MA116 is used.)

2. If the name, address, and ZIP Code where the test was performed is not entered in item 32, if the services were performed in a location other than the patient’s home or physician’s office. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

3. When a diagnostic service is billed as a purchased service and the service is purchased from another billing jurisdiction, the billing provider must submit their own NPI in Item 32a with the name, address, and ZIP Code of the performing provider in Item 32. If Item 32 and 32a are not entered, remark code MA114 is used.

J. For mammography “diagnostic” and “screening” claims, if a qualified screening center does not accurately enter their 6-digit, FDA-approved certification number in item 32 when billing the technical or global component. (Remark code MA128 is used.)

K. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name is not present in item 17 or if the NPI is not entered in item 17b of the Form CMS-1500. (Remark code N264 or N286 is used.)

L. For portable x-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist’s name, and/or NPI is not entered in items 17 or if the NPI is not entered in item 17b of the Form CMS-1500. (Remark code N264 or N286 is used.)

M. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist’s name, if appropriate, is not entered in items 17 or if the NPI is not entered in item 17b of the Form CMS-1500. (Remark code N264 or N286 is used.)

N. 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 (NPP) services, must have the name and NPI of the certifying physician or NPP of the therapy plan of care. For the purposes of processing professional claims, the certifying physician/NPP is considered a referring provider. For paper billing, the certifying physician/NPP name and NPI is entered in Items 17 and 17b. Providers and suppliers filing electronic claims are required to comply with applicable HIPAA ASC X12 837 claim completion requirements for reporting a referring provider. (See Pub. 100-04, chapter 5, §20 and Pub. 100-02, chapter 15, §§220 and 230 for therapy service policies.)

NOTE: For items 80.3.2.1.3 (g), (k), (l), (m), and (n) above, effective for claims with dates of services (DOS) on or after the implementation date of the Phase 2 ordering and referring denial edits, if the Part B clinical lab and imaging technical or global component claim, or Durable Medical Equipment, Prosthetics, and Orthotics Suppliers (DMEPOS) claim is denied due to the ordering/referring provider not allowed to order/refer, contractors shall use Group Code CO, Claim Adjustment Reason Code (CARC) 183 and Remittance Advice Remark Codes (RARCs) N574 and MA13. If the claim is denied due to the ordering/referring provider’s name not matching (i.e., the first four letters of the last name provided on the claim don’t match what’s listed in the provider’s record), contractors shall use Group Code CO, CARC 16, RARCs N264 and N575 and MA13.

If the claim is submitted that lists an ordering/referring provider and the required matching NPI is not reported, then the claim shall be rejected using Group Code CO, CARC 16, RARCs N265 and MA13. This is the only instance when a rejection is allowed.

O. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP Code, and NPI where the laboratory services were performed in item 32 or if the NPI is not entered into item 32a of the Form CMS-1500, if the services were performed at a location other than the place of service home – 12. (Use Remark code MA114.)

P. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998. (Remark code MA120 is used.)

Q. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23, for dates of service through March 31, 2008. (Remark code MA50 is used.) With the use of new modifier Q0, effective for dates of service on and after April 1, 2008, contractors will no longer be able to distinguish an IDE claim from other investigational clinical services. Therefore this edit will no longer apply.

R. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23. (Remark code MA49 is used.)

S. For Competitive Acquisition Program drug and biological claims, in accordance with the instructions found in the Medicare Claims Processing Manual, chapter 17, section 100.2.1 – section 100.9.

T. For claims for artificial hearts covered by Medicare under an approved clinical trial, if procedure code 0051T is entered in Item 24D, and an 8-digit clinical trial number that matches an approved clinical trial listed at: http://www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp#TopOfPage is not entered in Item 19; and the HCPCS modifier Q0 is not entered on the same line as the procedure code in Item 24D, and the diagnosis code V70.7 *(if ICD-9-CM is applicable) or Z00.6 (if ICD-10-CM is applicable)*is not entered in Item 21 and linked to the same procedure code. (As appropriate, use remark code MA97 – Missing/ incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number; M64 – Missing/incomplete/invalid other diagnosis; or claim adjustment reason code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.)

U. For clinical trial claims processed **after September 28, 2009**, with dates of service on or after January 1, 2008, claims submitted with either the modifier QV or the modifier Q1, if the diagnosis code V70.7 *(if ICD-9-CM is applicable) or Z00.6 (if ICD-10-CM is applicable)*is not submitted with the claim.

V. For ambulance claims, claims submitted without the ZIP Code of the loaded ambulance trip's point-of-pickup in Item 23 of Form CMS-1500.

80.3.2.2 - Consistency Edits for Institutional Claims

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

In order to be processed correctly and promptly, a bill must be completed accurately. Medicare contractors processing institutional claims edit all Medicare required fields as shown below. If a bill fails these edits, contractors return it to the provider for correction. If bill data is edited online, the edits are included in the software. Depending upon special services billed, contractors may require additional edits.

The following instructions follow the format of Form CMS-1450. For instructions about the location of these data elements on the ASC X12 837 institutional claim transaction format see the related implementation guide.

FL 4. Type of Bill

a. Must not be spaces.

b. Must be a valid code for billing. Valid codes are:

First Digit - Type of Facility:

1 - Hospital

NOTE: Hospital-based multi-unit complexes may also have use for the following first digits when billing non-hospital services:

2 - Skilled Nursing

3 - Home Health

4 - Religious Non-Medical (Hospital)

7 - Clinic or Renal Dialysis Facility (requires special information in second digit below)

8 - Special Facility or Hospital ASC Surgery (requires special information in second digit, see below)

Second Digit - Classification (if first digit is 1-5):

1 - Inpatient (Part A)

2 - Hospital-Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment)

3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment)

4 - Other (Part B) (includes HHA medical and other health services not under a plan of treatment, hospital and SNF for diagnostic clinical laboratory services for “nonpatients”)

8 - Swing bed (used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement)

Second Digit - Classification (first digit is 7):

1 - Rural Health Clinic (RHC)

2 - Hospital-Based or Independent Renal Dialysis Facility

4 - Other Rehabilitation Facility (ORF)

5 - Comprehensive Outpatient Rehabilitation Facility (CORF)

6 - Community Mental Health Center (CMHC)

7 - Free-Standing Provider-Based Federally Qualified Health Center (FQHC)

Second Digit - Classification (first digit is 8):

1 - Hospice (Nonhospital-based)

2 - Hospice (Hospital-based)

5 - Critical Access Hospital (CAH)

Third Digit - Frequency:

A - Admission/Election Notice

B - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Termination/Revocation Notice

C - Hospice Change of Provider

D - Hospice/Medicare Coordinated Care Demonstration/Religious Non-Medical Health Care Institution-Void/Cancel

E - Hospice Change of Ownership

F - Beneficiary Initiated Adjustment Claim (For *A/B MAC (A)* use only)

G - CWF Initiated Adjustment Claim (For *A/B MAC (A)* use only)

H - CMS initiated Adjustment Claim (For *A/B MAC (A)* use only)

I - *A/B MAC (A)* Adjustment Claim (Other than QIO or Provider) (For *A/B MAC (A)* use only)

J - Initiated Adjustment Claim-Other (For *A/B MAC (A)* use only)

K - OIG Initiated Adjustment Claim (For *A/B MAC (A)* use only)

M - MSP Initiated Adjustment Claim (For *A/B MAC (A)* use only)

P - QIO Adjustment Claim (For *A/B MAC (A)* use only)

Q – Claim Submitted for Reconsideration Outside of Timely Limits (For *A/B MAC (A)* use only)

0 - Nonpayment/zero claims

1 - Admit Through Discharge Claim

2 - Interim - First Claim

3 - Interim – Continuing Claims (Not valid for PPS bills. Exception: SNF PPS bills)

4 - Interim – Last Claim (Not valid for PPS bills. Exception: SNF PPS bills)

5 - Late charge

7 - Correction

8 - Void/Cancel

9 - Final Claim for a Home Health PPS Episode

FL 6. Statement Covers Period (From - Through)

a. Cannot exceed eight positions in either “From” or “Through” portion allowing for separations (nonnumeric characters) in the third and sixth positions.

b. The “From” date must be a valid date that is not later than the “Through” date.

c. The “Through” date must be a valid date that is not later than the current date.

d. With the exception of Home Health PPS claims, the statement covers period may not span 2 accounting years.

FL 09. Patient’s Address

a. The address of the patient must include:

City
State (P.O. Code)
ZIP

b. Valid ZIP Code must be present if the type of bill is 11X, 13X, 18X, or 83X or 85X.

c. Cannot exceed 62 positions.

FL 10. Birthdate

a. Must be valid if present.

b. Cannot exceed 10 positions allowing for separations (nonnumeric characters) in the third and sixth positions.

FL 11. Sex

a. One alpha position.

b. Valid characters are “M” or “F.”

c. Must be present.

FL 12. Admission Date

a. Must be valid if present.

b. Cannot exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions.

c. Present only if the type of bill is 11X, 12X, 18X, 21X, 22X, 32X, 33X, 41X, 81X or 82X.

FL 14. Priority (Type) of Admission or Visit

a. One numeric position.

b. Required only if the type of bill is 11X, 12X, 18X, 21X, 22X, or 41X.

FL 15. Point of Origin for Admission or Visit.

a. One numeric position

b. Must be present

FL 17. Patient Discharge Status.

a. Two numeric positions

b. Present on all Part A inpatient, SNF, hospice, home health agency, and outpatient hospital services. Types of bill: 11X, 12X, 13X, 14X, 18X, 21X, 22X, 23X, 32X, 33X, 34X, 41X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, 83X, or 85X.

FL 03b. Medical/Health Record Number

a. If provided by the hospital, must be recorded by the *A/B MAC (A)* for the QIO.

b. Must be left justified in CWF record for QIO.

FLs 18 thru 28. Condition Codes.

a. Each code is two numeric digits.

b. If code 07 is entered, type of bill must not be hospice 81X or 82X.

c. If codes 36, 37, 38, or 39 are entered, the type of bill must be 11X and the provider must be a non-PPS hospital or exempt unit.

d. If code 40 is entered, the "From" and "Through" dates in FL 6 must be equal, and there must be a "0" or "1" in FL 7 (Covered Days).

e. Only one code 70, 71, 72, 73, 74, 75, or 76 can be on an ESRD claim.

FLs 31, 32, 33, and 34. Occurrence Codes and Dates

a. All dates must be valid.

b. Each code must be accompanied by a date.

c. All codes are two alphanumeric positions.

d. If code 20 or 26 is entered, the type of bill must be 11X or 41X. If code 21 or 22 is entered, the type of bill must be 18X or 21X.

e. If code 27 is entered, the type of bill must be 81X or 82X.

f. If code 28 is entered, the first digit in FL 4 must be a "7" and the second digit a "5."

g. If code 42 is entered, the first digit in FL 4 must be "8" and the second digit "1" or "2" and the third digit "1 or 4."

h. If 01 - 04 is entered, Medicare cannot be the primary payer, i.e., Medicare-related entries cannot appear on the "A" lines of FLs 58-62.

i. If code 20 is entered:

- Must not be earlier than “Admission” date ~~(FL 17)~~ or later than “Through” date (FL 6).

- Must be less than 13 days after the admission date ~~(FL 17)~~ if “From” date is equal to admission date (less than 14 days if billing dates cover the period December 24 through January 2).

j. If code 21 is entered:

- Cannot be later than “Statement Covers Period” Through date; or

- Cannot be more than 3 days prior to the “Statement Covers Period” From date.

k. If code 22 is entered, the date must be within the billing period shown in FL 6.

l. If code 31 is entered, the type of bill must be 11X, 21X, or 41X.

m. If code 32 is entered, the type of bill must be 13X, 14X, 23X, 32X, 33X, 34X, 71X, 72X, 73X, 74X, 75X, 81X, or 82X.

FL 35 and 36. Occurrence Span Codes and Dates

a. Dates must be valid.

b. Code entry is two alphanumeric positions.

c. Code must be accompanied by dates.

d. If code 70 is entered, the type of bill must be 11X, 18X, 21X, or 41X.

e. If code 71 is entered, the first digit of FL 4 must be “1,” “2,” or “4” and the second digit must be “1.”

f. If code 72 is entered, the type of bill must be 11X, 12X, 13X, 14X, 18X, 21X, 22X, 23X, 32X, 34X, 71X, 72X, 73X, 74X, 75X, 76X, 77X, 81X, 82X, or 85X.

g. If code 74 is entered, the type of bill must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 74X, 75X, 81X, or 82X.

h. If code 75 is entered, the first digit of FL 4 must be “1” or “4” and the second digit must be “1.”

i. If code 76 is entered, occurrence code 31 must be present (inpatient only).

j. If code 76 is entered, occurrence code 32 must be present (outpatient only).

k. If code 76, 77, or M1 is present, the bill type must be 11X, 13X, 14X, 18X, 21X, 34X, 41X, 71X, 72X, 73X, 74X, 75X, 81X, 82X, or 85X.

l. Neither the “From” nor the “Through” portion can exceed eight positions allowing for separations (nonnumeric characters) in the third and sixth positions of each field.

m. If code M2 is present, the bill type must be 81X or 82X.

n. Code 79 is for payer use only. Providers do not report this code.

FLs 39, 40, and 41. Value Codes and Amounts.

a. Each code must be accompanied by an amount.

b. All codes are two alphanumeric digits.

c. Amounts may be up to ten numeric positions. (00000000.00)

d. If code 06 is entered, there must be an entry for code 37.

e. If codes 08 and/or 10 are entered, there must be an entry in FL 10.

f. If codes 09 and/or 11 are entered, there must be an entry in FL 9.

g. If codes 12, 13, 14, 15, 41, 43, or 47 are entered as zeros, occurrence codes 01, 02, 03, 04, or 24 must be present.

h. Entries for codes 37, 38, and 39 cannot exceed three numeric positions.

i. If the blood usage data is present, code 37 must be numeric and greater than zero.

FL 42. Revenue Codes.

a. Four numeric positions.

b. Must be listed in ascending numeric sequence except for the final entry, which must be "0001" for hardcopy claims only.

c. There must be a revenue code adjacent to each entry in FL 47.

d. For bill types 32X and 33X the following revenue codes require a 5-position HCPCS code:

0274, 029X, 042X, 043X, 044X, 055X, 056X, 057X, 0601, 0602, 0603, and 0604.

e. For bill type 34X, the following revenue codes require a 5-position HCPCS code:

0271-0274, 42X, 43X, 44X, and 0601-0604.

f. For bill type 21X, 32X, 33X, or 11X (IRF facilities) the following revenue codes require a 5-position HIPPS code:

0022 (SNF only), 0023 (HH only), 0024 (IRFs only).

FL 45. Service Date

a. Six numeric positions, MMDDYY.

b. A single line item date of service (LIDOS) is required on every revenue code present on types of bill 12X, 13X, 14X, 22X, 23X, 24X, 32X, 33X, 34X, 71X, 73X, 74X, 75X, 76X, 81X, 82X, and 83X.

Exception: LIDOS are not required for CAHs, Indian Health Service hospitals, and hospitals located in American Samoa, Guam, and Saipan.

c. When a particular service is rendered more than once during the billing period, the revenue code and HCPCS code must be entered separately for each service date.

FL 46. Units of Service

a. Up to seven numeric positions.

b. Must be present for all services with the exception of the HIPPS line item service. (Exception: Units are required on the HIPPS line for SNF claims)

c. ccommodation units must equal covered days with the exception of the R No-Pay.

FL 47. Total Charges

a. Up to 10 numeric positions (00000000.00).

b. There must be an entry adjacent to each entry in FL 42.

c. The “0001” amount must be the sum of all the entries for hardcopy only.

FLs 50A, B, and C. Payer Identification

a. "Medicare” must be entered on one of these lines depending upon whether it is the primary, secondary or tertiary payer.

b. If value codes 12, 13, 14, 15, 16, 41, 42, 43, or 47 are present, data pertaining to Medicare cannot be entered in Line A of FLs 50-62.

FL 56. National Provider Identifier – Billing Provider

a. Effective May 23, 2007, providers are required to submit their NPI.

b. Left justified.

FLs 58A, B, and C. Insured’s Name

a. Must be present. Cannot be all spaces.

FLs 60A, B, and C. Certificate/Social Security Number/HI Claim/Identification Number

a. Must be present.

b. Must contain nine numeric characters and at least one alpha character as a suffix. The first alpha suffix is entered in position 10, the second in position 11, etc. The first three numbers must fall within the range of 001 through 680 or 700 through 728.

c. The alpha suffix must be A through F, H, J, K, M, T, or W. Alpha suffixes A and T must not have a numeric subscript. Alpha suffixes B, C, D, E, F, M, and W may or may not have a numeric subscript.

d. If the alpha suffix is H, it must be followed by A, B or C in position eleven. The numeric subscript (position twelve) must conform with the above for the A, B, or C suffix to be used.

e. RRB claim numbers must contain either six or nine numeric characters, and must have one, two, or three character alpha prefix.

f. For prefixes H, MH, WH, WCH, PH and JA only a 6-digit numeric field is permissible. For all other prefixes, a six or nine numeric field is permissible.

g. Nine numeric character claim numbers must have the same ranges as the SSA 9-position claim numbers.

FL 67. Principal Diagnosis Code and Present on Admission Indicator.

a. *If ICD-9-CM, must be four or five positions left justified, with no decimal points. If ICD-10-CM, must be three to seven positions, left justified, with no decimal points.*

b. Must be valid ICD *diagnosis* code for *date of service*.

c. POA is a one position field.

FLs 67 A - Q. Other Diagnosis Codes and Present on Admission Indicator.

a. If present, *for ICD-9-CM must be four or five positions, left justified, with no decimal points. For ICD-10-CM must be three to seven positions, left justified, with no decimal points.*

b. POA is a one position field.

FL 74. Principal Procedure Code and Date

a. If present, must be valid procedure code for service date. *For ICD-9-CM must be 3 - 5 characters; first character may be numeric or alpha, characters 2 -5 must be numeric. For ICD-10-PCS must be 3 - 7 characters; first character must be alpha, second character must be numeric, characters 3 – 7 may be alpha or numeric.*

b. If code is present, date must be present and valid.

c. Date must fall before the "Through" date in FL 6. (In some cases it may be before the admission date, i.e., where complications and admission ensue from outpatient surgery.)

FL 74 a-e. Other Procedure Codes and Dates.

a. If present, apply edits for FL 74

FL 76. Attending Provider Name and Identifiers.

a. The UPIN must be present on inpatient Part A bills with a "Through" date of January 1, 1992, or later. For outpatient and other Part B services, the UPIN must be present if the "From" date is January 1, 1992, or later. This requirement applies to all provider types and all Part B bill types. Effective May 23, 2007, providers are required to submit NPI.

b. An institutional provider may not submit their own NPI, except for Institutional billing of influenza and pneumococcal vaccinations and their administration as the only billed service on a claim, roster billing of influenza and pneumococcal vaccinations and their administrations, self-referred screening mammography as the only billed service on a claim, or where the provider only has a type-1 NPI as a physician/practitioner owned sole-proprietor.

FL 77. Operating Physician Name and Identifiers

a. Effective May 23, 2007, providers are required to submit NPI. NPI must be present if:

- Bill type is 11X and a procedure code is shown in FL 74;

- Bill type is 83X or 13X and a HCPCS code is reported that is subject to the ASC payment limitation or is on the list of codes the QIO furnishes that require approval; or

- Bill type is 85X and HCPCS code is in the range of 10000 through 69979.

b. If required:

- NPI, last name and first initial must be present; and

- Left justified.

130.2 - Inpatient Part A Hospital Adjustment Bills

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

For adjustment requests *reported as a claim record, the hospital must report the ICN/DCN of the original bill. See the ASC X12 Institutional Claim Implementation Guide for instructions for the electronic format and Chapter 25 for instructions for Form CMS-1450.* Where payment is handled through the cost reporting and settlement processes, the hospital accumulates a log for those items not requiring an adjustment request. For cost settlement, the *A/B MAC (A)* pays on the basis of the log. This log must include:

- Patient name;
- HICN;
- Dates of admission and discharge, or from and thru dates;
- Adjustment in charges (broken out by ancillary or routine service); and
- Any unique numbering or filing code necessary for the hospital to associate the adjustment charge with the original billing.

NOTE: Hospitals in Maryland, which are not paid under PPS or cost reports, submit an adjustment request for inpatient care of $500 or more, and keep a log as described above for lesser amounts. Because there are no adjustment requests, the *A/B MAC (A)* enters the payment amounts from the summary log into the PPS waiver simulation and annually pays the items on the log after the cost report is filed.

After cost reports are filed, the *A/B MAC (A)* makes a lump sum payment to cover these charges as shown on the summary log. The hospital uses the summary log for late charges only under cost settlement (outpatient hospital), except in Maryland.

Maryland and cost hospitals are required to meet the 12-month timeframe for timely filing of claims, including late charges.

For all adjustments other than QIO adjustments (e.g., provider submitted adjustments and/or those the *A/B MAC (A)* initiates), the *A/B MAC (A)* submits an adjustment request to CWF following its acceptance of the initial bill. To verify CMS's acceptance, the *A/B MAC (A)* can submit a status query.

Under inpatient hospital prospective payment, adjustment requests are required from the hospital where errors occur in diagnosis and procedure coding that changes the DRG, or where the deductible or utilization is affected. A hospital is allowed 60 days from the date of the *A/B MAC (A)* payment notice (remittance advice) for adjustment requests where diagnostic or procedure coding was in error resulting in a change to a higher weighted DRG. Adjustments reported by the QIO have no corresponding time limit and are adjusted automatically by the *A/B MAC (A)* without requiring the hospital to submit an adjustment request. However, if diagnostic and procedure coding errors have no effect on the DRG, adjustment requests are not required.

Under PPS, for long-stay cases, hospitals may bill 60 days after an admission and every 60 days thereafter if they choose. The *A/B MAC (A)* processes the initial bill through Grouper and PRICER. When the adjustment request is received, it processes it as an adjustment. In this case, the 60-day requirement for correction does not apply.

190 – Payer-Only Codes Utilized by Medicare

(Rev. 3086, Issued: 10-03-14, Effective: **ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD-10; ASC X12: November 4, 2014)**

This section contains the listing of payer codes *and related Form CMS-1450 Form Locators* designated by the National Uniform Billing Committee to be assigned by payers only. Providers shall not submit these codes on their claims forms. The definitions indicating Medicare's usage for these systematically assigned codes are indicated next to each code value.

Condition Codes *CMS-1450* Form Locators (FLs) 18-28)

12-14 - Not currently used by Medicare.

15 - Clean claim is delayed in CMS Processing System.

16 - SNF Transition exception.

60 - Operating Cost Day Outlier.

61 - Operating Cost Outlier.

62 - PIP Bill.

63 - Bypass CWF edits for incarcerated beneficiaries. Indicates services rendered to a prisoner or a patient in State or local custody meets the requirement of 42 CFR 411.4(b) for payment.

64 - Other Than Clean Claim.

65 - Non-PPS Bill.

98 -Data Associated With DRG 468 Has Been Validated.

EY - Lung Reduction Study Demonstration Claims.

M0 - All-Inclusive Rate for Outpatient - Used by a Critical Access Hospital electing to be paid an all-inclusive rate for outpatient services.

M1 - Roster Billed Influenza Virus Vaccine or Pneumococcal Pneumonia Vaccine (PPV). Code indicates the influenza virus vaccine or pneumonia vaccine (PPV) is being billed via the roster billing method by providers that mass immunize.

M2 - Allows Home Health claims to process if provider reimbursement > $150,000.00. HHA Payment Significantly Exceeds Total Charges. Used when payment to an HHA is significantly in excess of covered billed charges.

M3 - M9 Not used by Medicare.

MA - GI Bleed.

MB - Pneumonia.

MC - Pericarditis.

MD - Myelodysplastic Syndrome.

ME - Hereditary Hemolytic and Sickle Cell Anemia.

MF - Monoclonal Gammopathy.

MG-MZ – Not currently used by Medicare.

UU – Not currently used by Medicare.

Occurrence Codes (FLs 31-34)

23 - Date of Cancellation of Hospice Election period.

48-49 - Not currently used by Medicare.

Occurrence Span Codes (FLs 35-36)

79 - Verified non-covered stay dates for which the provider is liable.

Value Codes (FLs 39-41)

17- Operating Outlier Amount – The A/B MAC *(A)* reports the amount of operating outlier payment amount made (either cost or day (day outliers have been obsolete since 1997)) in CWF with this code. It does not include any capital outlier payment in this entry.

18 - Operating Disproportionate Share Amount – The A/B MAC *(A)* REPORTS THE OPERATING DISPROPORTIONATE SHARES AMOUNT APPLICIALBE. It uses the amount provided by the disproportionate share field in PRICER. It does not include any PPS capital IME adjustment entry.

19 - The Medicare shared system will display this payer only code on the claim for low volume providers to identify the amount of the low volume adjustment being included in the provider's reimbursement. This payer only code 19 is also used for IME on hospital claims. This instruction shall only apply to ESRD bill type 72x and must not impact any existing instructions for other bill types.

19 - Operating Indirect Medical Education Amount – The A/B MAC *(A)* reports operating indirect medical education amount applicable. It uses the amount provided by the indirect medical education field in PRICER. It does not include any PPS capital IME adjustment in this entry.

20 - Total payment sent provider for capital under PPS, including HSP, FSP, outlier, old capital, DSH adjustment, IME adjustment, and any exception amount.

62 - HH Visits - Part A - The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

63 - HH visits – Part B - The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

64 - HH Reimbursement – Part A - The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

65 - HH Reimbursement – Part B - The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B Trust Fund as mandated by §1812(a)(3) of the Social Security Act.

70 - Interest Amount - The contractor reports the amount of interest applied to this Medicare claim.

71 - Funding of ESRD Networks - The A/B MAC *(A)* reports the amount the Medicare payment was reduced to help fund ESRD networks.

72- Flat Rate Surgery Charge - The standard charge for outpatient surgery where the provider has such a charging structure.

73- Sequestration adjustment amount.

74 - Not currently used by Medicare.

75- Prior covered days for an interrupted stay.

76 - Provider's Interim Rate –Provider's percentage of billed charges interim rate during this billing period. This applies to all outpatient hospital and skilled nursing facility (SNF) claims and home health agency (HHA) claims to which an interim rate is applicable. The contractor reports to the left of the dollar/cents delimiter. An interim rate of 50 percent is entered as follows: 50.00.

77 - Medicare New Technology Add-On Payment - Code indicates the amount of Medicare additional payment for new technology.

78 - Payer only value code. When the facility zip (Loop 2310E N403 Segment) is present for the following bill types: 12X, 13X, 14X, 22X, 23X, 34X, 72X, 74X, 75X, 81X, 82X, and 85X. The zip code is associated with this value and is used to price MPFS HCPCS and Anesthesia Services for CAH Method II.

79 - The Medicare shared system will display this payer only code on the claim. The value represents the dollar amount for Medicare allowed payments applicable for the calculation in determining an outlier payment.

Q0 - Accountable Care Organization reduction.

Q1 - Q9 – Not used by Medicare.