CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1690	**Date: FEBRUARY 27, 2009**
	Change Request 6362

Subject: Reporting the National Provider Identifier (NPI) on Claims for Reference Laboratory and Purchased Diagnostic Services Performed Outside the Billing Jurisdiction.

I. SUMMARY OF CHANGES: This instruction gives clarification on billing instructions on the use of the NPI on Medicare claims for reference laboratory or purchased diagnostic service when the service is performed outside of the billing jurisdiction. The billing provider shall report their own NPI with the name, address, and zip code of the performing physician/supplier. This also supplements and manualizes CR 5289 which was issued October 27, 2006 as Transmittal 243.

New / Revised Material
Effective Date: March 27, 2009
Implementation Date: March 27, 2009

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	1/80/80.3.2.1.3/Carrier Specific Requirements for Certain Specialties/Services
R	16/40/40.1.1.1/Paper Claim Submission to Carriers/B MAC
R	16/40/40.1.1.2/Electronic Claim Submission to Carriers/B MAC

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1690	Date: February 27, 2009	Change Request: 6362

SUBJECT: Reporting the National Provider Identifier (NPI) on Claims for Reference Laboratory and Purchased Diagnostic Service Performed Outside the Billing Jurisdiction

Effective Date: March 27, 2009

Implementation Date: March 27, 2009

I. GENERAL INFORMATION

A. Background: This transmittal establishes an exception to the standard reporting of the national provider identifier (NPI) on certain Medicare fee-for-service claims for reference laboratory and purchased diagnostic services.

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandate the adoption of a standard unique health identifier for health care providers. The final rule, published on January 23, 2004 establishes the NPI as this standard. All entities covered under HIPAA must comply with the requirements of the regulation at 45 CFR Part 162, CMS-0045-F, which requires that covered health care providers, suppliers, and health plans (other than small plans) are required to use the NPI effective May 23, 2008. Specifically, every provider must report its NPI on a paper or electronically-submitted Medicare fee-for-service claim.

Certain Medicare-covered services may be outsourced by the billing provider to another Medicare-enrolled provider. In such a circumstance, the outsourced service is "purchased" by the billing provider who must not only report its own NPI (as the billing provider) but also annotate the claim with the performing provider's NPI. However, when the performing provider is located in a contractor jurisdiction different from that of the billing provider, the contractor will not have a record of the performing provider's NPI. In this latter circumstance, the billing provider is permitted to annotate its own NPI as the performing provider's NPI in order for the claim to be adjudicated by Medicare. However, the billing provider must keep the performing provider's NPI in the clinical records for auditing purposes.

Previously the foregoing described reporting convention was discretionary. This transmittal establishes this reporting convention as a requirement.

B. Policy: When a provider bills for a reference laboratory service listed on the Clinical Laboratory Fee Schedule for a purchased diagnostic service performed by a provider located in another contractor jurisdiction, the billing provider in addition to reporting its own NPI on the Medicare claim (as the billing provider), must also report its own NPI as the performing provider and annotate the claim with the name, address, and ZIP code of the performing provider.

N.B.: In this Transmittal, the term "provider" shall be construed to also mean "physician or other supplier" if the context requires such alternative meaning.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6362.1	Carriers/AB MACs shall accept the billing provider's NPI in lieu of the performing provider's NPI on a claim for a reference laboratory service or a purchased diagnostic service that is performed outside the billing jurisdiction.	X			X						
6362.2	Carriers/AB MACs shall return as unprocessable a claim for a reference laboratory service or a purchased diagnostic service that is performed outside the billing jurisdiction when submitted without a NPI in Item 32a and the name, address, and ZIP code of the performing provider in Item 32 of the CMS-1500 form.	X			X						
6362.3	Carriers/AB MACs shall return as unprocessable a claim for a reference laboratory service or a purchased diagnostic service that is performed outside the billing jurisdiction when submitted without a NPI and the name, address, and ZIP code of the performing provider on the ANSI X12 837P electronic claim form in the appropriate data field.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6362.4	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

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

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr at Wendy.Knarr@cms.hhs.gov or dial Relay #711 and have agent dial 410-786-0843 and/or Eric Coulson at Eric.Coulson@cms.hhs.gov or (410) 786-3352.

Post-Implementation Contact(s): Your appropriate RO.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)* and *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *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.

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services

(Rev. 1690; Issued: 02-27-09; Effective/Implementation Date: 03-27-09)

Carriers 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, ZIP Code, and PIN number, until the NPI is required, is not entered in item 33 or if the NPI is not entered in item 33a.of the Form CMS-1500 (8/05) when the NPI is required or, until the NPI is required, if their personal PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required. (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, until the NPI is required, the attending physician's PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required). (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 PIN (or NPI when required) 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 their UPIN (until the NPI is required) is not present in 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required. (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 their UPIN (until the NPI is required) is not present in 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required. (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 their UPIN (until the NPI is required) is not present in item 17a. or if the NPI is not entered in item 17b.of the Form CMS-1500 (8/05) when the NPI is required). (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 UPIN (or NPI when required) is not entered in items 17 or their UPIN (until the NPI is required) is not entered in item 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required). (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 or 17 or their UPIN (until the NPI is required) is not entered in item 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required. (Remark code N264 or N286 is used.)

n. For outpatient physical or occupational therapy services provided by a qualified, independent physical, or occupational therapist, Medicare policy does not require the date last seen by a physician, or the UPIN or NPI, when required, of such physician. Medicare policy does not require identification of the ordering, referring or certifying physician on outpatient therapy claims, including speech-language pathology service claims. However, providers and suppliers are required to comply with applicable HIPAA ASC X12 837 claim completion requirements. See Pub. 100-04, chapter 5, §20 and Pub. 100-02, chapter 15, §§220 and 230 for therapy service policies. Deletion of this claim requirement for outpatient therapy services does not apply to the requirements for the date last seen and the UPIN or NPI, when required, of the ordering and supervising physician/nonphysician practitioner for therapy services provided incident to the services of a physician, because the incident to policies continue to require them.

1. If the UPIN (or NPI when required) of the attending physician is not present in item 19. (Remark code N253 is used.)

2. If the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen by the attending physician is not present in item 19. (Remark code N324 is used.)

o. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP Code, and PIN (until the NPI is required) where the laboratory services were performed in item 32 or if the NPI is not entered into item 32a. of the Form CMS-1500 (8/05) when the NPI is required), 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 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.)

Medicare Claims Processing Manual
Chapter 16 - Laboratory Services

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(Rev. 1690, 03-27-09)

120.1 - Negotiated Rulemaking Implementation

120.2 – Implementation and Updates of Negotiated National Coverage Determinations (NCDs) or Clinical Diagnostic Laboratory Services

40.1.1.1 - Paper Claim Submission To Carriers/B MAC

(Rev. 1690; Issued: 02-27-09; Effective/Implementation Date: 03-27-09)

An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90.

An independent clinical laboratory that submits claims in paper format) may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing Medicare). A paper claim that contains both non-referred and referred tests is returned as unprocessable. When the referring laboratory is the billing laboratory, the reference laboratory's *name, address, and zip code* shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. *The NPI shall be reported in item 32a.* Also, the CLIA number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form. *A paper claim that does not have the name, address, and ZIP code of the reference laboratory in item 32 and NPI in 32a* or the CLIA number of the reference laboratory in item 23 is returned as unprocessable.

EXAMPLE: A physician has ordered the ABC Laboratory to perform carcinoembryonic antigen (CEA) and hemoglobin testing for a patient. Since the ABC Laboratory is approved to perform tests only within the hematology LC level (which includes the hemoglobin test), it refers the CEA testing (which is a routine chemistry LC) to the XYZ laboratory.

Result: The ABC laboratory submits a claim for the hemoglobin test and reports its CLIA number in item 23 on the CMS-1500 form. Since the ABC laboratory referred the CEA test to the XYZ laboratory to perform, the ABC laboratory (billing laboratory) submits a second claim for the CEA testing, reporting XYZ's CLIA number in item 23 on the CMS-1500 form. *The XYZ laboratory's name, address, and ZIP code are also reported in item 32 and the NPI is reported in item 32a on Form CMS-1500 to show where the service (test) was actually rendered.*

NOTE:

When the reference laboratory is not located in the same billing jurisdiction as the referring laboratory, the referring (billing) laboratory shall use their own NPI for reporting purposes.

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. The billing provider should keep a record of the performing provider's NPI in the clinical records for auditing purposes.

40.1.1.2 - Electronic Claim Submission to Carriers/B MAC

(Rev. 1690; Issued: 02-27-09; Effective/Implementation Date: 03-27-09)

Electronic Claim Submission

American National Standards Institute (ANSI) X12N 837 (HIPAA version) format electronic claims:

CLIA number:

An ANSI claim for laboratory testing will require the presence of the performing (and billing) laboratory's CLIA number; if tests are referred to another laboratory, the CLIA number of the laboratory where the testing is rendered must also be on the claim. An ANSI electronic claim for laboratory testing must be submitted using the following format:

ANSI Electronic claim: the billing laboratory performs all laboratory testing.

The independent laboratory submits a single claim for CLIA-covered laboratory tests and reports the billing laboratory's number in:

X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

ANSI Electronic claim: billing laboratory performs some laboratory testing; some testing is referred to another laboratory.

The ANSI electronic claim will not be split; CLIA numbers from both the billing and reference laboratories must be submitted on the same claim. The presence of the '90' modifier at the line item service identifies the referral tests. Referral laboratory claims are only permitted for independently billing clinical laboratories, specialty code 69.

The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA number in:

X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4

EXAMPLE: A physician has ordered the DEF independent laboratory to perform glucose testing and tissue typing for a patient. Since the DEF Laboratory is approved to perform only at the routine chemistry LC level (which includes glucose testing), it refers the tissue-typing test to the GHI laboratory.

The DEF laboratory submits a single claim for the glucose and tissue typing tests; the line item service for the glucose test is submitted without a '90' modifier since the DEF laboratory performed this test. The CLIA number for the DEF laboratory is entered in the electronic claim in:

X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

On the same claim, the line item service for the tissue typing test is submitted with a '90' modifier and the referral/rendering GHI laboratory's CLIA number is entered on the electronic claim in:

X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4

Reference Laboratory's Address:

An electronic claim for laboratory testing requires the presence of the performing and billing laboratory's, name and address. The performing laboratory for a service with a line item CPT 90 modifier requires provider information for the appropriate 837 loop.

NOTE:

When the reference laboratory is not located in the same billing jurisdiction as the referring laboratory, the referring (billing) laboratory shall use their own NPI for reporting purposes.

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 with the name, address, and ZIP code of the performing provider in the appropriate data field. The billing provider should keep a record of the performing provider's NPI in the clinical records for auditing purposes.