

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1867	Date: December 4, 2009
	Change Request 6718

SUBJECT: Requirements to Prevent the Misuse of Modifiers PA, PB, and PC on Incoming Claims

I. SUMMARY OF CHANGES: The PA, PB and PC modifiers are often being submitted incorrectly on claims. This can cause incorrect denials. This CR will help to alleviate the issue.

New / Revised Material

Effective Date: January 15, 2009

Implementation Date: No later than January 4, 2010.

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	1/80/3.2.1.2/Conditional Data Element Requirements for Carriers and DMERCs

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

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SUBJECT: Requirements to Prevent the Misuse of Modifiers PA, PB and PC on Incoming Claims

Effective Date: January 15, 2009

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I. GENERAL INFORMATION

A. Background: Change Request (CR) 6405, Transmittal 1778, “Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient,” a revised version of which was issued on September 25, 2009, implemented billing procedures for these adverse events. It has come to the attention of the Centers for Medicare and Medicaid Services that the new modifiers developed in the CR are, in many cases, being submitted incorrectly by the providers. In particular, some providers are using the PC modifier to represent the professional component of a service. This is incorrect. The PC modifier is defined as “Wrong Surgery on a Patient.” The incorrect use of this modifier results in claims being incorrectly denied. Contractors shall follow the requirements in this CR to help prevent claims from being processed with modifiers incorrectly submitted on them. In effect, this will also serve as an educational effort and for the most part should alleviate the issue in a short period of time.

B. Policy: This CR makes no change in policy to the coverage/non-coverage of the adverse events described in CR 6405.

II. BUSINESS REQUIREMENTS TABLE

Use “Shall” to denote a mandatory requirement

Number	Requirement	Responsibility (place an “X” in each applicable column)									
		A / B M A C	D M M A C	F I M A C	C A R I E R	R H H I	Shared-System Maintainers				OTHE R
					F I S S	M I C S	V M S	C M S	W F		
6718.1	Contractors shall suspend, review, and develop all claim lines that are submitted with the PA, PB, or PC modifiers.	X		X	X						
6718.2	Contractors shall make a contact with the provider to determine whether the claims are related to one of the adverse events as described by the modifiers PA, PB, or PC.	X		X	X						
6718.2.1	If the contractor determines that the modifiers PA, PB, or PC have been incorrectly submitted, they shall RTP hospital outpatient claims.	X		X							
6718.2.2	If the contractor determines that the modifiers PA, PB, or PC have been incorrectly submitted, they shall	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B	D M E	F I	C A R R I E R	R H I	Shared-System Maintainers				OTHE R
							F I S S	M C S	V M S	C W F	
	return physician/practitioner claims as unprocessable.										
6718.2.2.1	The contractor shall return the following Claim Adjustment Reason Code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. and Remittance advice Remark Code MA130 – 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.	X			X						
6718.3	Contractors shall not forward any information concerning these rejected or returned claims to the other contractors.	X		X	X						
6718.4	Should contractors realize that they have added an occurrence to the list established in BR 6405.1.5 and BR 6405.2.3 that they have now determined is incorrect, they shall remove that occurrence from their list and reprocess claims that have been incorrectly denied.	X		X	X						
6718.4.1	On a weekly basis by mail or FAX, contractors shall notify the Points of Contact at the other contractors to remove the HIC # from their lists.	X		X	X						
6718.4.2	Contractors receiving that notification should remove the HIC # from their lists and reprocess claims that may have been incorrectly denied as related to an adverse event.	X		X	X						
6718.5	Contractors shall note that per BR 6405.2 from CR 6405 it is appropriate for the modifiers PA, PB, or PC to be applied to all services related to the adverse event.	X		X	X						
6718.5.1	Contractors shall note that they shall not limit the use of the modifiers PA, PB, or PC only to surgical procedure codes.	X		X	X						
6718.6	Contractors shall not go back and search for erroneously processed claims, but shall adjust payment for claims brought to their attention.	X		X	X						
6718.6.1	Contractors shall then remove these claims from the list and on a weekly basis, by mail or FAX, notify the Points of Contact at the other contractors of the change.	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H I I S S	Shared-System Maintainers				OTHE R
						F I S S	M C S	V M S	C W F		
6718.6.2	Contractors notified of the change shall also remove them from their lists.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I M A C	C A R R I E R	R H I I S S	Shared-System Maintainers				OTHER
						F I S S	M C S	V M S	C W F		
6718.7	<p>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.</p> <p>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.</p>	X		X	X						

IV. SUPPORTING INFORMATION

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

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
6405	Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgical or Other Invasive Procedure Performed on the Wrong Body Part; Surgical or Other Invasive Procedure Performed on the Wrong Patient
6718.2.1	Contractors shall create a reason code (7XXXX range) instructing the provider to verify

X-Ref Requirement Number	Recommendations or other supporting information:
	the modifiers, once verified if resubmitted DENY with 36460.

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

V. CONTACTS

Pre-Implementation Contact(s):

Institutional Claims Processing:

Joe Bryson at Joseph.Bryson@cms.hhs.gov

Valeri Ritter at Valeri.Ritter@cms.hhs.gov

Practitioner Claims Processing:

Leslie Trazzi at Leslie.Trazzi@cms.hhs.gov

Tom Dorsey at Thomas.Dorsey@cms.hhs.gov

Post-Implementation Contact(s): Regional Office.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*, use only one of the following statements:

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)*, include the following statement:

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.

80.3.2.1.2 - Conditional Data Element Requirements for Carriers and DMERCs

(Rev. 1867; Issued: 12-04-09; Effective Date: 01-15-09; Implementation Date: No later than 01-04-10.)

A - Universal Requirements

The following instruction describes “conditional” data element requirements, which are applicable to assigned carrier 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), carriers 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 (hardcopy) have been provided. These items are referred to as fields in the instruction.

Carriers must return a claim as unprocessable to the supplier/provider of service in the following circumstances:

- a. 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 and/or NPI is not present in item 17 or 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N285 or N286 is used)
- b. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or NPI is required of the supervising physician is not entered in items 17 or 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N269 or N270 is used.)
- c. For diagnostic tests subject to purchase price limitations:
 1. If a “YES” or “NO” is not indicated in item 20. Carriers/AB MACs shall assume the service is not purchased. This claim shall not be returned as unprocessable for this reason only.
 2. If the “YES” box is checked in item 20 and a required purchase price is not entered under the word “\$CHARGES.” (Remark code MA111 is used.)
 3. If the “YES” box is checked in item 20 and the purchase price is entered under “\$CHARGES”, but the supplier’s name, address, ZIP Code, the NPI is not entered into item 32a of the Form CMS-1500 (8/05) when billing for purchased diagnostic tests. (Remark code N256, N257, or N258 are used.)

Entries 4 – 8 are effective for claims received on or after April 1, 2004:

4. On the Form CMS-1500, if the “YES” box is checked in Item 20, and more than one test is billed on the claim;
 5. On the Form CMS-1500, if both the interpretation and test are billed on the same claim and the dates of service and places of service do not match;
 6. On the Form CMS-1500, if the “YES” box is checked in Item 20, both the interpretation and test are submitted and the date of service and place of service codes do not match.
 7. On the ANSI X12N 837 electronic format, if there is an indication on the claim that a test has been purchased, more than one test is billed on the claim, and line level information for each total purchased service amount is not submitted for each test.
 8. On the Form CMS-1500 if the “YES” box is checked in Item 20 and on the ANSI X12N 837 electronic format if there is an indication on the claim that a test has been purchased, and the service is billed using a global code rather than having each component billed as a separate line item.
- d. If a provider of service or supplier is required to submit a diagnosis in item 21 and either an ICD-9CM code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. (Remark code M81 or M76 are used.)
 - e. If modifiers “QB” and “QU” or, effective on or after January 1, 2006, the modifier "AQ" are entered in item 24D indicating that the service was rendered in a Health Professional Shortage Area, but where the place of service is other than the patient’s home or the physician’s office, the name, address, and ZIP Code of the facility where the services were furnished are not entered in item 32. (Remark code MA115 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.
 - f. 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 (08-05) 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.)
 - g. 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.)
 - h. 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 PlanID when effective) is not entered in field 11C,

or the primary payer's program or plan name when a Payer or Plan ID (use PlanID when effective) does not exist. (Remark code MA92 or N245 is used.)

- i. 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.)
- j. 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.)
- k. 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.)
- l. 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 contractors 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.)

- m 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 (08-05) in item 32.

n. 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.)