CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2500	Date: July 27, 2012
	Change Request 7871

SUBJECT: Clarification of the Use of the Electronic Claim Format to Indicate Where a Service Was Performed

I. SUMMARY OF CHANGES: This change will serve to clarify the use of the electronic format to submit information on where a service was rendered.

EFFECTIVE DATE: August 27, 2012
IMPLEMENTATION DATE: August 27, 2012

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	1/10.1.1/Payment Jurisdiction Among Local B/MACs for Services Paid Under the Physician Fee Schedule and Anesthesia
R	1/10.1.1.1/Claims Processing Instructions for Payment Jurisdiction
R	1/80.3.2.1.2/Conditional Data Element Requirements for A/B MACs and DMEMACs

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

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

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2500	Date: July 27, 2012	Change Request: 7871

SUBJECT: Clarification of the Use of the Electronic Claim Format to Indicate Where a Service Was Performed

Effective Date: **August 27, 2012**

Implementation Date: August 27, 2012

I.   GENERAL INFORMATION

A.   Background: Currently in the Medicare Internet Only Manual (IOM), there are instructions for pricing purposes about entering on electronic claims the address of where a service was performed. This instruction will serve to clarify that the information should be entered according to the appropriate ANSI X12 Implementation Guide.

B.   Policy: There is no change to policy.

II.   BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.
Use "Should" to denote an optional requirement.

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A/B MAC	DME MAC	FI	CARRIER	RHHI	FISS	MCS	VMS	CWF
7871.1	Contractors shall note that the IOM has been updated to more clearly reflect that the submission of information on electronic claims should correspond to the appropriate ANSI X12 Implementation Guide.	X			X					
7871.2	Contractors shall note that this clarification reflects no change to current processing but just clarifies the information in the IOM.	X			X					

III.   PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/B	DME	FI	CAR	RHH	Shared-System Maintainers	OTHER

		M A C	M A C		R I E R	I	F I S S	M C S	V M S	C W F	
None.											

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:
	N/A

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

V. CONTACTS

Pre-Implementation Contact(s): Leslie Trazzi at leslie.trazzi@cms.hhs.gov.

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* **and/or** *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.

10.1.1 - Payment Jurisdiction Among Local B/MACs for Services Paid Under the Physician Fee Schedule and Anesthesia Services
(Rev. 2500, Issued: 07-27-12, Effective: 08-27-12, Implementation: 08-27-12)

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, B/MACs must use the ZIP code of the location where the service was rendered to determine B/MAC 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, B/MACs 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 B/MAC's service area (e.g., provider has separate offices in multiple localities and/or multiple B/MACs), separate claims must be submitted to the appropriate area B/MACs 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 B/MAC's service area (e.g., Indiana), the B/MAC which processes claims for the payment locality where the out of office service was furnished has jurisdiction for that service. It is the B/MAC 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 B/MAC 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 local B/MAC 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 B/MACs 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 MFSDB 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 B/MAC 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 B/MAC 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 B/MAC 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 B/MAC for processing. However, the specific location where the services were furnished must be entered on the claim so the B/MAC 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. B/MACs 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. B/MACs 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.

B MACs 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 ANSI X12N 827 P electronic claim form, *submission of the complete address of where the service was performed will be required regardless of where the service was*

*performed. This information should be entered on the claim per the Implementation Guide for the 5010 version. C*ontractors 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 Form CMS-1500, 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 B/MAC Jurisdiction

If B/MACs 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, B/MACs 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 B/MACs, 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. 2500, Issued: 07-27-12, Effective: 08-27-12, Implementation: 08-27-12)

A. Instructions for the 4010/4010A1 Version of the ANSI X12N 837 P Electronic Claim Form

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 ANSI X12N 837 P.

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 ANSI X12N 837 P

Following the requirements of the Implementation Guide of the 5010 version of the ANSI X12N 837 P, 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 carrier 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 carrier'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 B/MACs 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, carriers shall price the claim using the carrier/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	
Carrier	8	12	5	
Pricing Locality	13	14	2	
Rural Indicator	15	15	1	blank=urban, R=rural, B=super rural
Filler	16	20	5	
Plus Four Flag	21	21	1	0 = no +4 extension, 1 = +4 extension
Plus Four	22			

80.3.2.1.2- Conditional Data Element Requirements for A/B MACs and DMEMACs
(Rev. 2500, Issued: 07-27-12, Effective: 08-27-12, Implementation: 08-27-12)

A - 80.3.2.1.2 Universal Requirements

The following instruction describes "conditional" data element requirements, which are applicable to certain assigned A/B MAC 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 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.

A/B MACs processing claims on the Form CMS-1500 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 the technical component (TC) and professional component (PC) of diagnostic tests subject to the anti-markup payment limitation:

   1. If a "YES" or "NO" is not indicated in item 20 and no acquisition price is entered under the word "$CHARGES." A/B MACs 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.

   2. 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.)

   3. 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.)

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

5. 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 (8/05) when billing for diagnostic services subject to the anti-markup payment limitation. (Remark code N294 is 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 TC and PC 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 TC and PC 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 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.

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 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.

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. Available for future use.

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 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, if 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, is not entered on the claim. (See Pub.100-04, Chapter 1, sections 10.1.1 and 10.1.1.1) . (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.)