CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2767	**Date: August 16, 2013**
	Change Request 8356

SUBJECT: Handling of Incomplete or Invalid Claims once the Phase 2 Ordering and Referring Edits are Implemented

I. SUMMARY OF CHANGES: The purpose of this change request is to revise the handling of incomplete or invalid claims submitted for Part B clinical lab and imaging technical or global component claims, Home Health Agency (HHA) claims and Durable Medical Equipment, Prosthetics, and Orthotics Suppliers (DMEPOS) claims once the Phase 2 ordering and referring edits are implemented.

EFFECTIVE DATE: January 1, 2014
IMPLEMENTATION DATE: January 6, 2014

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/Handling Incomplete or Invalid Claims
R	1/80.3.2.1.2/Conditional Data Element Requirements for A/B MACs and DMEMACs
R	1/80.3.2.1.3/Carrier Specific Requirements for Certain Specialties/Services

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
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2767	Date: August 16, 2013	Change Request: 8356

SUBJECT: Handling of Incomplete or Invalid Claims once the Phase 2 Ordering and Referring Edits are Implemented

EFFECTIVE DATE: January 1, 2014
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I. GENERAL INFORMATION

A. Background: Current guidance instructs contractors to return claims as unprocessable when a service is ordered or referred by a physician or non-physician practitioner 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. Effective for claims with dates of service (DOS) on or after the implementation date of the ordering and referring phase 2 edits, Part B clinical lab and imaging technical or global component claims, Home Health Agency (HHA) claims and Durable Medical Equipment, Prosthetics, claims shall be denied, in accordance with CMS-6010-F final rule published on April 24, 2012, if the ordering or referring provider's information is missing, invalid or if the provider is not of a specialty that is eligible to order and refer.

B. Policy: Section 6405(a) of the Affordable Care Act amended section 1834(a)(11)(B) of the Social Security Act to specify, with respect to suppliers of durable medical equipment, that payment may be made under that subsection only if the written order for the item has been communicated to the DMEPOS supplier by a physician who is enrolled under section 1866(j) of the Act or an eligible professional under section 1848(k)(3)(B) who is enrolled under section 1866(j) before delivery of the item. Section 1128J(e) requires that he or she be identified by his or her National Provider Identifier (NPI) in claims for those services. Medicare requires the ordering supplier (the physician or the eligible professional) to be identified by legal name and NPI in the claim submitted by the supplier of DMEPOS.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8356.1	Contractors shall observe the policy clarifications outlined in this change request.		X		X		X						
8356.2	Effective for claims with dates of service (DOS) on or after the implementation date of the ordering and referring phase 2 edits, contractors shall deny Part B clinical lab and imaging technical or global component claims, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies claims if the ordering or referring provider's information is invalid or if the provider is not of a specialty that is eligible to order and refer.		X		X		X						

Number	Requirement	Responsibility												
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8356.3	Contractors shall only reject a claim that lists an ordering/referring provider or supplier if the required NPI is not reported. This is the only instance when a rejection is allowed.		X		X		X						
8356.4	Contractors shall be notified via a Technical Direction Letter (TDL) when CMS requires the edits to be turned on for claims to deny.		X		X		X						
8356.5	Contractors shall continue to process ordering and referring claims as they currently do until such instruction is given to contractors as indicated in BR 8356.4.		X		X		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		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:
	None.

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Alisha Banks, 410-786-0671 or Alisha.Banks@cms.hhs.gov, Tolla Anderson, 410-786-1786 or Tolla.Anderson@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; Contractors activities are to be carried out with 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 do 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.

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

80.3.2 - Handling Incomplete or Invalid Claims

(Rev.2767, Issued: 08-16-13, Effective: 01-01-14, Implementation: 01-06-14)

Claims processing specifications describe whether a data element is required, not required, or conditional (a data element which is required when certain conditions exist). The status of these data elements will affect whether or not an incomplete or invalid claim (hardcopy or electronic) will be "returned as unprocessable" or “returned to provider” (RTP) by the carrier or FI, respectively. The carrier or FI shall not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction. (See §80.3.1 for Definitions.)

If a data element is required and it is not accurately entered in the appropriate field, the carrier or FI returns the claim to the provider of service.

- If a data element is required, or is conditional (a data element that is required when certain conditions exist) and the conditions of use apply) and is missing or not accurately entered in its appropriate field, return as unprocessable or RTP the claim to either the supplier or provider of service.

  NOTE: Effective for claims with dates of service (DOS) on or after the implementation date of the ordering and referring phase 2 edits, Part B clinical lab and imaging technical or global component claims, Durable Medical Equipment, Prosthetics, claims and Home Health Agency (HHA) claims shall be denied, in accordance with CMS-6010-F final rule published on April 24, 2012, if the ordering or referring provider’s information is invalid or if the provider is not of a specialty that is eligible to order and refer.

- If a claim must be returned as unprocessable or RTP for incomplete or invalid information, the carrier or FI must, at minimum, notify the provider of service of the following information:

  - Beneficiary’s Name;
  - Claim Number; HIC Number or HICN or Health Insurance Claim Number. This has never been HI Claim Number.
  - Dates of Service (MMDDCCYY) (Eight-digit date format effective as of October 1, 1998);
  - Patient Account or Control Number (only if submitted);
  - Medical Record Number (FIs only, if submitted); and
  - Explanation of Errors (e.g., Remittance Advice Reason and Remark Codes)

NOTE: Some of the information listed above may in fact be the information missing from the claim. If this occurs, the carrier or FI includes what is available.

Depending upon the means of return of a claim, the supplier or provider of service has various options for correcting claims returned as unprocessable or RTP for incomplete or invalid information. They may submit corrections either in writing, on-line, or via telephone when the claim was suspended for development, or submit as a “corrected” claim or as an entirely new claim if data from the original claim was not retained in the system, as with a front-end return, or if a remittance advice was used to return the claim. The chosen

mode of submission, however, must be currently supported and appropriate with the action taken on the claim.

NOTE: The supplier or provider of service must not be denied any services (e.g., modes of submission or customer service), other than a review, to which they would ordinarily have access.

- If a claim or a portion of a claim is "returned as unprocessable" or RTP for incomplete or invalid information, the carrier or FI does not generate an MSN to the beneficiary.

- The notice to the provider or supplier will not contain the usual reconsideration notice, but will show each applicable error code or equivalent message.

- If the carrier or FI uses an electronic or paper remittance advice notice to return an unprocessable claim, or a portion of unprocessable claim:

    1. The remittance advice must demonstrate all applicable error codes. However, there must be a minimum of two codes on the remittance notice (including code Remittance Advice Remark Code : MA130).

    2. The returned claim or portion must be stored and annotated, as such, in history, if applicable. If contractors choose to suspend and develop claims, a mechanism must be in place where the carrier or FI can re-activate the claim or portion for final adjudication.

A. Special Considerations

- If a "suspense" system is used for incomplete or invalid claims, the carrier or FI will not deny the claim with appeal rights if corrections are not received within the suspense period, or if corrections are inaccurate. The carrier must return the unprocessable claim through the remittance process, without offering appeal rights, to the provider of service or supplier. The FI uses the RTP process.

  For assigned and unassigned claims submitted by beneficiaries (Form CMS-1490S), that are incomplete or contain invalid information, contractors shall manually return the claims to the beneficiaries. If the beneficiary furnishes all other information but fails to supply the provider or supplier's NPI, and the contractor can determine the NPI using the NPI registry, the contractor shall continue to process and adjudicate the claim. If the contractor determines that the provider or supplier was not a Medicare enrolled provider with a valid NPI, the contractor shall follow previously established procedures in order to process and adjudicate the claim.

  Contractors shall send a letter to the beneficiary with information explaining which information is missing, incorrect or invalid; information explaining the mandatory claims filing requirements; instructions for resubmitting the claim if the provider or supplier refuses to file the claim, or enroll in Medicare, and shall include language encouraging the beneficiary to seek non-emergency care from a provider or supplier that is enrolled in the Medicare program. Contractors shall also notify the provider or supplier about his/her obligation to submit claims on behalf of Medicare beneficiaries and that providers and suppliers are required to enroll in the Medicare program to receive reimbursement.

  Contractors shall consider a complete claim to have all items on the Form CMS-1490S completed along with an itemized bill with the following information: date of service, place of service, description of each surgical or medical service or supply furnished; charge for each service; treating doctor's or supplier's name and address; diagnosis code; procedure code and the provider or supplier's NPI. Required information on a claim must be valid for the claim to be considered as complete.

If a beneficiary submits a claim on the Form CMS-1500, return the Form CMS-1500 claim to the beneficiary, and include a copy of the Form CMS-1490S, along with a letter instructing the beneficiary to complete and return the Form CMS-1490S for processing within the time period prescribed in §70.5 above. Include in the letter a description of missing, invalid or incomplete items required for the Form CMS-1490S that were not included with the submitted Form CMS-1500 or were invalid.

NOTE: Telephone inquiries are encouraged.

- The carrier or FI shall not return an unprocessable claim if the appropriate information for both "required" and "conditional" data element requirements other than an NPI when the NPI is effective is missing or inaccurate but can be supplied through internal files. Contractors shall not search their internal files to correct missing or inaccurate "required" and "conditional" data elements required under Sections 80.3.2.1.1 through 80.3.2.1.3 and required for HIPAA compliance for claims governed by HIPAA.

- For either a paper or electronic claim, if all "required" and "conditional" claim level information that applies is complete and entered accurately, but there are both "clean" and "dirty" service line items, then split the claim and process the "clean" service line item(s) to payment and return as unprocessable the "dirty" service line item(s) to the provider of service or supplier**. NOTE:** This requirement applies to carriers only.

No workload count will be granted for the "dirty" service line portion of the claim returned as unprocessable. The "clean" service line portion of the claim may be counted as workload **only if it is processed through the remittance process**. Contractors must abide by the specifications written in the above instruction; return the "dirty" service line portion without offering appeal rights.

- Workload will be counted for claims returned as unprocessable through the remittance process. Under no circumstances should claims returned as unprocessable by means other than the remittance process (e.g., claims returned in the front-end) be reported in the carrier or FI workload reports submitted to CMS. The carrier or FI is also prohibited from moving or changing the action on an edit that will result in an unprocessable claim being returned through the remittance process. If the current action on an edit is to suspend and develop, reject in the front or back-end, or return in the mailroom, the carrier or FI must continue to do so. Workload is only being granted to accommodate those who have edits which currently result in a denial. As a result, workload reports should not deviate significantly from those reports prior to this instruction.

NOTE: Rejected claims are not counted as an appeal on resubmissions.

B. Special Reporting of Unprocessable Claims Rejected through the Remittance Process (Carriers Only):

Carriers must report "claims returned as unprocessable on a remittance advice" on line 15 (Total Claims Processed) and on line 14 (subcategory Non-CWF Claims Denied) of page one of your Form CMS-1565. Although these claims are technically not denials, line 14 is the only suitable place to report them given the other alternatives. In addition, these claims should be reported as processed "not paid other" claims on the appropriate pages (pages 2-9) of CROWD Form T for the reporting month in which the claims were returned as unprocessable through the remittance process. Also, carriers report such claims on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) system. They report the "number of such claims returned during the month as unprocessable through the remittance process" under Column 1 of Form Y on a line using code "0003" as the identifier.

If a supplier, physician, or other practitioner chooses to provide missing or invalid information for a suspended claim by means of a telephone call or in writing (instead of submitting a new or corrected claim),

carriers do not report this activity as a claim processed on Form CMS-1565/1566. Instead, they subtract one claim count from line 3 of Form Y for the month in which this activity occurred.

EXAMPLE: Assume in the month of October 2001 the carrier returned to providers 100 claims as unprocessable on remittance advices. The carrier should have included these 100 claims in lines 14 and 15 of page 1 of your October 2001 Form CMS-1565. During this same month, assume the carrier received new or corrected claims for 80 of the 100 claims returned during the month. These 80 claims should have been counted as claims received in line 4 of your October 2001 Form CMS-1565 page one (and subsequently as processed claims for the reporting month when final determination was made).

Also, during October 2001, in lieu of a corrected claim from providers, assume the carrier received missing information by means of a telephone call or in writing for 5 out of the 100 claims returned during October 2001. This activity should not have been reported as new claims received (or subsequently as claims processed when adjustments are made) on Form CMS-1565. On line 3 of Form Y for October 2001, the carrier should have reported the number 95 (From claims returned as unprocessable through the remittance process minus 5 claims for which the carrier received missing or invalid information by means of a telephone call or in writing.

For the remaining 15 claims returned during October 2001 with no response from providers in that same month, the carrier should have reported on the Form CMS-1565 or Form Y, as appropriate, any subsequent activity in the reporting month that it occurred. For any of these returned claims submitted as new or corrected claims, the carrier should have reported their number as receipts on line 4 of page one of Form CMS-1565. For any of these returned claims where the supplier or provider of service chose to supply missing or invalid information by means of a telephone call or in writing, the carrier should not have counted them again on Form CMS-1565, but subtracted them from the count of returned claims reported on line 3 of Form Y for the month this activity occurred.

C. Exceptions (Carrier Only)

The following lists some exceptions when a claim may not be “returned as unprocessable” for incomplete or invalid information.

Carriers shall not return a claim as unprocessable:

If a patient, individual, physician, supplier, or authorized person’s signature is missing, but the signature is on file, or if the applicable signature requirements have been met, do not return a claim as unprocessable where an authorization is attached to the claim or if the signature field has any of the following statements (unless an appropriate validity edit fails):

Acceptable Statements for Form CMS-1500:

- For items 12, 13, and 31, “Signature on File” statement and/or a computer generated signature;
- For items 12 and 13, Beneficiary’s Name “By” Representative’s Signature;

For item 12, “X” with a witnessed name and address. (Chapter 26 for instructions.)

D. Misdirected Claims

See §10.1.9 for instructions on handling claims that are submitted to the wrong contractor, or to the wrong payment jurisdiction.

80.3.2.1.2 - Conditional Data Element Requirements for A/B MACs and DMEMACs

(Rev.2767, Issued: 08-16-13, Effective: 01-01-14, Implementation: 01-06-14)

A - 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.)

NOTE: *For item 80.3.2.1.2 (a) 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 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.

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. 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 (08-05) and an ICD-9-CM “E” code (external causes of injury and poisoning) is reported in the Number 1 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 Number1 field of Item 21. (Remark Code MA63 is used.)

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 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 ANSI X12N 837 P electronic claim form 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.)

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.)

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services

(Rev.2767, Issued: 08-16-13, Effective: 01-01-14, Implementation: 01-06-14)

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, 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 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 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 the CMS-1500 Form.