CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3510	**Date: April 29, 2016**
	Change Request 9578

SUBJECT: Updates to Pub. 100-04, Chapters 1 and 16 to Correct Remittance Advice Messages

I. SUMMARY OF CHANGES: This Change Request revises chapters 1 and 16 of the Medicare Claims Processing Manual to ensure that all remittance advice coding is consistent with nationally standard operating rules. It also provides a format for consistently showing remittance advice coding throughout this manual.

EFFECTIVE DATE: October 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016

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	1/10.1.1.1/Claims Processing Instructions for Payment Jurisdiction
R	1/10.1.9.1/An A/B MAC (B) Receives a Claim for Services that are in Another A/B MAC (B)’s Payment Jurisdiction
R	1/10.1.9.2/An A/B MAC (B) Receives a Claim for Services that are in a DME MAC’s Payment Jurisdiction
R	1/10.1.9.3/A DME MAC Receives a Claim for Services that are in an A/B MAC (B)’s Payment Jurisdiction
R	1/10.1.9.4/An A/B MAC (B) Receives a Claim for an RRB Beneficiary
R	1/10.1.9.5/An A/B MAC (B) or DME MAC Receives a Claim for a UMWA Beneficiary
R	1/10.1.9.9/A DME MAC receives a Paper Claim with Items or Services that are in Another DME MAC's Payment Jurisdiction
R	1/10.5.1/Implementation of Payment Policy for Deported Medicare Beneficiaries
R	1/30.3.1.1/Processing Claims for Services of Participating Physicians or Suppliers
R	1/30.3.13/Charges for Missed Appointments
R	1/60.5/Coding That Results from Processing Noncovered Charges
R	1/80.3.2/Handling Incomplete or Invalid Claims
R	1/80.3.2.1.1/A/B MAC (B) Data Element Requirements
R	1/80.3.2.1.2/Conditional Data Element Requirements for A/B MACs and DMEMACs
R	1/80.3.2.1.3/A/B MAC (B) Specific Requirements for Certain Specialties/Services
R	16/10.2/General Explanation of Payment
R	16/50.2.1/Assignment Required
R	16/70.10.1/Physician Notification of Denials
R	16/70.11/Reasons for Denial - Physician Office Laboratories Out-of-Compliance

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not 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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3510	Date: April 29, 2016	Change Request: 9578

SUBJECT: Updates to Pub. 100-04, Chapters 1 and 16 to Correct Remittance Advice Messages

EFFECTIVE DATE: October 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016

I. GENERAL INFORMATION

A. Background: Section 1171 of the Social Security Act requires a standard set of operating rules to regulate the health insurance industry's use of electronic data interchange (EDI) transactions. Operating Rule 360: Uniform Use of CARCs and RARCs, regulates the way in which group codes, claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) may be used. The rule requires specific codes which are to be used in combination with one another if one of the named business scenarios applies. This rule is authored by the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE).

Medicare and all other payers must comply with the CAQH CORE-developed code combinations. The business scenario for each payment adjustment must be defined, if applicable, and a valid code combination selected for all remittance advice messages. This CR updates chapters 1 and 16 of the manual to reflect the standard format and to correct any non-compliant code combinations. Additional CRs will follow to provide similar revisions to the remaining chapters of Pub. 100-04.

B. Policy: Remittance coding used by Medicare Administrative Contractors shall be compliant with nationally standard CAQH/CORE operating rules.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
9578.1	The contractor shall ensure that they apply remittance advice coding as described in the revised instructions in Pub. 100-04, chapters 1 and 16. Note: Changes to codes that require systems changes are described in the requirements that follow.	X	X		X					
9578.2	The contractor shall apply the following remittance advice codes when out of jurisdiction professional claims are rejected as unprocessable:		X		X		X			

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code: CO CARC: 109 RARC: N104 Note: The prior instruction also included RARC MA130. This code shall no longer be used.									
9578.3	The contractor shall apply the following remittance advice codes when misdirected Railroad Retirement Board claims are rejected as unprocessable: Group Code: CO CARC: 109 RARC: N105 Note: The prior instruction also included RARC MA130. This code shall no longer be used.		X				X			
9578.4	The contractor shall apply the following remittance advice codes when misdirected United Mine Workers Association claims are rejected as unprocessable: Group Code: CO CARC: 109 RARC: N127 Note: The prior instruction also included RARC MA130. This code shall no longer be used.		X		X		X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9578.5	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	

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:

Section B: All other recommendations and supporting information:

V. CONTACTS

Pre-Implementation Contact(s): Tiera Canty, tiera.canty@cms.hhs.gov (for chapter 16 changes) , Wil Gehne, wilfried.gehne@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev. 3510, 04-16)

10.1.1.1 - Claims Processing Instructions for Payment Jurisdiction

(Rev. 3510 , Issued:04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

A. Instructions for the 4010/4010A1 Version of the ASC X12 837 Professional Electronic Claim (for Claims Processed Before Implementation of Version 5010)

Note that the following instructions do not apply to services rendered at POS home -12. For services rendered at POS home – 12, use the address on the beneficiary file for the beneficiary's home (or wherever else the beneficiary information is currently being stored) to determine pricing locality. *(*See §10.1.1 for changes to processing for services rendered at POS home – 12.)

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

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

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

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

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

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

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

C. Paper Claims Submitted on the Form CMS-1500

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

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

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

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: M77
MSN: 9.2

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

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

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

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

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

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

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

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

For claims received that require a 9-digit ZIP code with a 4-digit extension that does not match a 4-digit extension on file, manually verify the 4-digit extension to identify a potential coding error on the claim or a new 4-digit extension established by the U.S. Postal Service (USPS). ZIP code and county information may be found at the USPS Web site at http://www.usps.com/, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. The "Revision to Payment Policies Under the Physician Fee Schedule" that is published annually in the Federal Register, or any other available resource, may be used to determine the appropriate payment locality for the ZIP code with the new 4-digit extension. If this process does not validate the ZIP code, the claim shall be treated as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: MA114
MSN: N/A

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

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

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

E. ZIP9 Code to Locality Record Layout

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

ZIP9 Code to Locality Record Layout
(Effective for dates of service on or after October 1, 2007.)

Field Name	Beg. Position	End Position	Length	Comments
State	1	2	2	
ZIP Code	3	7	5	
A/B MAC (B)	8	12	5	
Pricing Locality	13	14	2	
Rural Indicator	15	15	1	Blank=urban R=rural B=super rural
Filler	16	20	5	
Plus Four Flag	21	21	1	0=no+4 extension 1=+4 extension
Plus Four	22	25	4	

10.1.9.1 – An A/B MAC (B) Receives a Claim for Services that are in Another A/B MAC (B)'s Payment Jurisdiction

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local contractor (Part B MAC or carrier) receives a CMS-1500 or electronic claim for Medicare payment for items/services furnished outside of its payment jurisdiction, the claim shall be returned as unprocessable.

NOTE: This instruction also applies to claims for DMEPOS items/services that are appropriately billed to the B MAC/carrier, but are billed to the wrong B MAC/carrier payment jurisdiction.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N104
MSN: N/A

10.1.9.2 – An A/B MAC (B) Receives a Claim for Services that are in a DME MAC's Payment Jurisdiction

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local contractor (Part B MAC or carrier) receives a CMS-1500 or electronic claim for Medicare payment for items/services that are in a DME MAC's payment jurisdiction, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N104
MSN: N/A

10.1.9.3 - A DME MAC Receives a Claim for Services that are in an A/B MAC (B)'s Payment Jurisdiction

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local DME MAC receives a CMS-1500 or electronic claim for Medicare payment for items/services that are in a Part B MAC or carrier's payment jurisdiction, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N104
MSN: N/A

10.1.9.4 – An A/B MAC (B) Receives a Claim for an RRB Beneficiary

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local contractor (Part B MAC or carrier) receives a Form CMS-1500 or electronic claim that is identified as a RRB claim for Medicare payment that should be processed by the RRB contractor, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N105
MSN: N/A

NOTE: CMS requests that when RRB receives a claim that is not for an RRB beneficiary that they return the claim to the sender and notify them that the claim must be submitted to the local contractor (Part B MAC or carrier) or DME MAC for processing.

10.1.9.5 – An A/B MAC (B) or DME MAC Receives a Claim for a UMWA Beneficiary

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a local contractor (Part B MAC or carrier/DME MAC) receives a Form CMS-1500 or electronic claim that is identified as a UMWA claim for Medicare payment that should be processed by the UMWA, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO

CARC: 109
RARC: N127
MSN: N/A

10.1.9.9 - A DME MAC receives a Paper Claim with Items or Services that are in Another DME MAC's Payment Jurisdiction

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

When a DME MAC receives a claim submitted on the Form CMS-1500 for Medicare payment that should be processed by a DME MAC but was sent to the wrong DME MAC, the claim shall be returned as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 109
RARC: N104
MSN: N/A

DME MACs shall continue to follow existing procedures for misdirected beneficiary-submitted claims and electronic claims.

10.5.1 - Implementation of Payment Policy for Deported Medicare Beneficiaries

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

A. CWF Editing of Claims

1. An auxiliary file shall be established in the Common Working File to contain deportation status.

2. This auxiliary file will be the basis for an edit that rejects claims submitted by Medicare contractors.

3. The edit will reject a claim where the beneficiary HIC number on the claim matches the HIC number on the Master Beneficiary Record and the date of service is on or after the date of deportation.

B. *Contractors Actions*

Medicare contractors shall deny claims for items and services when rejected by CWF. The contractor shall refer to the CWF documentation on this subject for the error code assigned to this editing. All denials will provide appeal rights as specified in section 10.5.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 96
RARC: N126
MSN: 16.56

30.3.1.1 - Processing Claims for Services of Participating Physicians or Suppliers

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

The participating physician or supplier submits any claims for services furnished by the physician or supplier, except in the limited circumstances specified in §30.2.8.3 or §30.2.16. (The exception concerns situations where the physician or supplier accepts, as full payment, payment by certain organizations.) When an unassigned claim is received from a physician, the *A/B MAC (B)* must verify that the physician is participating. The *contractor* processes the claim as assigned absent clear evidence of intent by the physician or beneficiary not to assign.

Any Form CMS-1500 claim where the participating physician or supplier checks either the assignment or non-assignment block or fails to check either block, the *A/B MAC (B)*must treat it as assigned.

Where there is evidence of clear intent not to assign, the *A/B MAC (B)* must deny the claim. Use MSN 16.6.

> "This item or service cannot be paid unless the provider accepts assignment.

In Spanish:

> "Este artículo o servicio no se pagará a menos de que el proveedor acepte asignación."

A/B MAC (B) must identify and track assignment violations in the event sanctions must be imposed.

No Part B payment is made on a claim by a participating physician or supplier to anyone other than the physician or supplier (except in the case of court-ordered assignment to other parties under §30.2) even if the beneficiary has paid part of the bill. However, if the physician or supplier collects any charges from the beneficiary before submitting the claim, he/she must show on the claim form the amount collected. The carrier refunds directly to the beneficiary, to the extent feasible, any over collection of deductible and coinsurance. The physician is responsible for refunding to the beneficiary any over collection not refunded by the carrier directly. In these latter instances, the carrier advises the physician of his/her obligation to refund any over collections to the beneficiary. Also, the carrier advises the beneficiary of the amount of any refund due from the physician.

30.3.13 – Charges for Missed Appointments

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity. Therefore, if a physician's or supplier's missed appointment policy applies equally to all patients (Medicare and non-Medicare), then the Medicare law and regulations do not preclude the physician or supplier from charging the Medicare patient directly.

The amount that the physician or supplier charges for the missed appointment must apply equally to all patients (Medicare and non-Medicare), in other words, the amount the physician/supplier charges Medicare beneficiaries for missed appointments must be the same as the amount that they charge non-Medicare patients (whatever amount that may be).

With respect to Part A providers, in most instances a hospital outpatient department can charge a beneficiary a missed appointment charge without violating its provider agreement and 42 CFR 489.22. Because 42 CFR 489.22 applies only to inpatient services, it does not restrict a hospital outpatient department from imposing charges for missed appointments by outpatients. In the event, however, that a hospital inpatient misses an

appointment in the hospital outpatient department, it would violate 42 CFR 489.22 for the outpatient department to charge the beneficiary a missed appointment fee.

Medicare does not make any payments for missed appointment fees/charges that are imposed by providers, physicians, or other suppliers. Charges to beneficiaries for missed appointments should not be billed to Medicare.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 204
RARC: N/A
MSN: 16.59

60.5- Coding That Results from Processing Noncovered Charges

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

Codes Returned to Providers and Beneficiaries

After processing is complete, remittance advice notices are used to explain to providers the difference between the charges they submitted for payment and what Medicare paid on their claim. The Medicare Summary Notice, or MSN, is used at the same time to inform beneficiaries about any payments made on their behalf.

Liability for noncovered charges is communicated using the Group Code on the remittance advice. When the beneficiary is liable, contractors use Group Code PR. When the provider is liable, contractors use Group Code CO.

Contractors shall deny services that are submitted with modifier GZ.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 50
RARC: N/A
MSN: 8.81

Contractors shall deny services that are submitted with modifier GY.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: PR
CARC: 96
RARC: N425
MSN: 16.10

Codes Used by Medicare Contractors

Medicare contractors use nonpayment codes when transmitting institutional claims to CWF in cases where payment is not made. Claims where partial payment is made do not require nonpayment codes.

Both the shared system for institutional claims and CWF react to CMS-created non-payment codes on entirely noncovered claims. The standard system must enter the appropriate code in the "Non-payment Code" field of the CWF record if the non-payment situation applies to all services present on the claim. It does not enter the nonpayment code when either partial payment is made, or payment is made in full by an insurer primary to Medicare. These codes alert CWF to bypass edits in processing that are not appropriate in nonpayment cases. Nonpayment codes also alert CWF to update a beneficiary's utilization records (deductible, spell of illness, etc.) in certain situations. Nonpayment codes themselves do not assign liability to provider or beneficiary on Medicare claims.

Medicare contractors and systems use the following nonpayment codes:

Code	Contractor Uses	Effect on Processing
B	Placed on Part B-paid inpatient claims when prior to claim 'From' date either: • Benefit and/or lifetime reserve days are exhausted; • Full day or coinsurance days are exhausted; • Beneficiaries elected not to use lifetime reserve days.	• Charges are processed as noncovered; • utilization not chargeable; • cost report days not applied.
R	Placed on claims when: • SNF inpatient services are denied for reasons other than lack of medical necessity or care being custodial in nature; • Provider failed to file claims within timely filing limits; • Beneficiary refused to request benefit on a claim.	• Charges are processed as noncovered and there is no payment; • utilization is chargeable and some charges may go to CWF as covered to update utilization correctly; • cost report days not applied.
N	Placed on claims when the provider is liable and: • The provider knew, or should have known, Medicare Part A or B would not pay; • Care billed was not paid by Medicare because either custodial or not reasonable or necessary; • Provider failed to submit requested documentation.	• Charges are processed as noncovered; • utilization not chargeable; • cost report days are applied.
N	Placed on claims when the beneficiary is liable and: • Statutory exclusions (e.g., most dental care and cosmetic surgery that Medicare never covers); • Claims not filed within timely filing limits BUT provider not at fault;	• Charges are shown as noncovered ; • neither utilization nor cost report days are reported.

	• Medicare decision find the beneficiary 'at fault' under limitation of liability • Inpatient psychiatric reduction applies because days are used in advance of admission (see IOM Pub. 100-02, Chapter 4); • All services provided after date active care in psychiatric hospital ended; • Inpatient hospital or SNF benefit provided after date covered care ended; • MSP cost avoidance denials (see IOM Pub. 100-05).	
No code entered	Despite no payment, no code is entered because: • Deductible/coinsurance exceeds the payment amount; • Other payer paid for all Medicare covered care such as: EGHP; LGHP; auto, no-fault, WC or other liability insurance (including BL); NIH, PHS, VA or other governmental entity or liability insurance; • Care was provided to a MA (Medicare Part C) enrollee when that part of Medicare, not Original Medicare, has jurisdiction for payment.	

Other than the distinct codes used for Medicare Secondary Payer (MSP) cost-avoided claims, entirely noncovered outpatient claims use either an "N" or "R" nonpayment code. Generally, the R code should be used instead of the N code in all cases where a spell of illness must be updated.

The HH spell of illness must be updated when processing noncovered HH PPS claims in certain situations. Accordingly, the shared systems must update home health value codes 62-65 when the R code is used, filling the values associated with the codes as zeros, since these value codes are needed to effectuate information related to the A-B Shift in the home health spell. CWF consistency edits related to the R nonpayment code will be bypassed in these cases. The CWF will update the dates of earliest and latest billing activity (DOEBA and DOLBA) for the benefit period, but not for the episode.

80.3.2 - Handling Incomplete or Invalid Claims

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

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" *by the A/B MAC (B)* or "returned to provider" (RTP) by the *A/B MAC (A)*. The *contractor* 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 *contractor* 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, the *contractor shall* 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 *contractor shall*, 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 *contractor* 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 *contractor* 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 *contractor* 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. At a minimum there must be a *CARC/RARC combination that is compliant with CAQH CORE Business Scenario Two.*

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 *contractor* 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 contractor will not deny the claim with appeal rights if corrections are not received within the suspense period, or if corrections are inaccurate. The *contractor* must return the unprocessable claim, without offering appeal rights, to the provider of service or supplier.

  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.

- *Contractors* 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 workload reports submitted to CMS. The *contractor* 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 *contractor* 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):

A/B MACs (B) 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, *A/B MACs (B)* 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), *A/B MACs (B)* 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 *A/B MAC (B)* 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 *A/B MAC (B)* 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 *A/B MAC (B)* 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 (*A/B MACs (B)* Only)

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

A/B MACs (B) 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.

80.3.2.1.1 - *A/B MAC (B)* Data Element Requirements

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

A - Required Data Element Requirements

1 - Paper Claims

The following instruction describes certain data element formatting requirements to be followed when reporting the calendar year date for the identified items on the Form CMS-1500:

- If birth dates are furnished in the items stipulated below, then these items must contain 8-digit birth dates (MMDDCCYY). This includes 2-digit months (MM) and days (DD), and 4-digit years (CCYY).

Form CMS-1500 Items Affected by These Reporting Requirements:

Item 3 - Patient's Birth Date

Item 9b - Other Insured's Date of Birth

Item 11a - Insured's Date of Birth

Note that 8-digit birth dates, when provided, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line.

If a birth date is provided in items 3, 9b, or 11a, and is not in 8-digit format, carriers must return the claim as unprocessable.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N329
MSN: N/A

If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b, or 11a. and the birth date is not in 8-digit format. However, if carriers use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

For certain other Form CMS-1500 conditional or required date items (items 11b, 14, 16, 18, 19, or 24A.), when dates are provided, either a 6-digit date or 8-digit date may be provided.

If 8-digit dates are furnished for any of items 11a., 14, 16, 18, 19, or 24A. (excluding items 12 and 31), carriers must note the following:

- All completed date items, except item 24A., must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line;

- Item 24A. must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24A. will penetrate the dotted, vertical lines used to separate month, day, and year. Carrier claims processing systems will be able to process the claim if the date penetrates these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24A;

- Do not compress or change the font of the “year” item in item 24A. to keep the date within the confines of item 24A. If a continuous number is furnished in item 24A. with no spaces between month, day, and year, you will not need to compress the “year” item to remain within the confines of item 24A.;

- The “from” date in item 24A. must not run into the “to” date item, and the “to” date must not run into item 24B.;

- Dates reported in item 24A. must not be reported with a slash between month, day, and year; and

- If the provider of service or supplier decides to enter 8-digit dates for any of items 11b, 14, 16, 18, 19, or 24A. (excluding items 12 and 31), an 8-digit date must be furnished for all completed items. For instance, you cannot enter 8-digit dates for items 11b, 14, 16, 18, 19 (excluding items 12 or 31), and a 6-digit date for item 24A. The same applies to those who wish to submit 6-digit dates for any of these items.

A/B MACs (B) must return claims as unprocessable if they do not adhere to these requirements.

2 - Electronic Claims

A/B MACs (B) must return all electronic claims that do not include an 8-digit *birth* date (CCYYMMDD) when a date is reported.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N329
MSN: N/A

If *A/B MACs (B)* do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b., or 11a. and the birth date is not in 8-digit format. However, if *A/B MACs (B)* do use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

B - Required Data Element Requirements

The following Medicare-specific, return as unprocessable requirements in this section and the following two sections are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations implementing HIPAA require the use of National Provider Identifiers (NPIs) by covered health care providers and health plans. Although not required by HIPAA, CMS is extending the requirement to include the NPI on electronic claims to paper claims submitted on the Form CMS-1500. *A/B MACs (B)* are referred to the Health Care Claims Professional 837 Implementation guide for requirements for professional claims subject to HIPAA, including the NPI reporting requirements.

A/B MACs (B) must return a claim as unprocessable to a provider of service or supplier and use the indicated *remittance advice codes.*

Carriers shall return a claim as unprocessable:

1. If a claim lacks a valid Medicare Health Insurance Claim Number (HICN) in item 1a. or contains an invalid HICN in item 1a.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: MA61
MSN: N/A

2. If a claim lacks a valid patient's last and first name as seen on the patient's Medicare card or contains an invalid patient's last and first name as seen on the patient's Medicare card.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: MA36
MSN: N/A

3. If a claim does not indicate in item 11 whether or not a primary insurer to Medicare exists.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: MA83 and MA92
MSN: N/A

4. If a claim lacks a valid patient or authorized person's signature in item 12 or contains an invalid patient or authorized person's signature in item 12. (See "Exceptions," bullet number one.)

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: MA75
MSN: N/A

5. If a claim lacks a valid "from" date of service in item 24A or contains an invalid "from" date of service in item 24A.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: M52
MSN: N/A

6. If a claim lacks a valid place of service (POS) code in item 24B or contains an invalid POS code in item 24B, return the claim as unprocessable to the provider or supplier. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, if a claim contains more than one POS (other than Home – 12), for services paid under the MPFS and anesthesia services.

Effective January 1, 2011, for claims processed on or after January 1, 2011 on the Form CMS-1500, if a claim contains more than one POS, including Home – 12, (or any POS contractors consider to be Home), for services paid under the MPFS and anesthesia services.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO

CARC: 16
RARC: M77
MSN: N/A

7. If a claim lacks a valid procedure or HCPCS code in item 24D or contains an invalid or obsolete procedure or HCPCS code in item 24D.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: M20
MSN: N/A

8. If a claim lacks a charge for each listed service.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: M79
MSN: N/A

9. If a claim does not indicate at least 1 day or unit in item 24G. (Note: To avoid returning the claim as "unprocessable" when the information in this item is missing, the *A/B MAC (B)* must program the system to automatically default to "1" unit).

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: M53
MSN: N/A

10. If a claim lacks a signature from a provider of service or supplier, or their representative. (See "Exceptions," bullet number one.)

For a missing provider representative signature:

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: MA70 (for a missing provider representative signature) or MA81 (For a missing physician/supplier/practitioner signature)
MSN: N/A

11. If a claim does not contain in item 33:

a. A billing name, address, ZIP Code, and telephone number of a provider of service or supplier.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N256 (for missing name) or N258 (for missing address)
MSN: N/A

AND EITHER

b. A valid PIN number or, for DMERC claims, a valid National Supplier Clearinghouse number (NPI in item 33a. of the Form CMS-1500 when the NPI is required) for the performing provider of service or supplier who is not a member of a group practice.

OR

c. A valid group PIN (or NPI when required) number or, for DMERC claims, a valid National Supplier Clearinghouse number (NPI in item 33a. of the Form CMS-1500, when the NPI is required) for performing providers of service or suppliers who are members of a group practice.

12. If a claim does not contain in Item 33a., Form CMS 1500, the NPI, when required, of the billing provider, supplier, or group.

13. Effective May 23, 2008, if a claim contains a legacy provider identifier, e.g., PIN, UPIN, or National Supplier Clearinghouse number.

NOTE: Claims are not to be returned as unprocessable in situations where an NPI is not required (e.g., foreign claims, deceased provider claims, other situations as allowed by CMS in the future) and legacy numbers are reported on the claim. Such claims are to be processed in accordance with the established procedures for these claims.

For 11.b through 13:
The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N257
MSN: N/A

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

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

A - Universal Requirements

The following instruction describes “conditional” data element requirements, which are applicable to certain assigned A/B MAC (B) claims. This instruction is minimal and does not include all “conditional” data element requirements, which are universal for processing claims.

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

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

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

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N285 (for missing name) or N286 (for missing identifier)
MSN: N/A

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

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N269 (for missing name) or N270 (for missing identifier)
MSN: N/A

NOTE: For item 80.3.2.1.2 -1 above, effective for claims with dates of service (DOS) on or after the implementation date of the Phase 2 ordering and referring denial edits, a Part B clinical lab and imaging technical or global component claim or Durable Medical Equipment, Prosthetics, and Orthotics Suppliers (DMEPOS) claim is denied *when* the ordering/referring provider not allowed to order/refer.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 183
RARC: N574, MA13
MSN: 21.6

The claim is denied *when the first four letters of the last name provided on the ordering/referring provider's claim does not match what is listed in the provider's record.*

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N264, MA13, N575
MSN: 21.6

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. This is the only instance when a rejection is allowed.

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: N265, MA13
MSN: N/A

For 3 through 12 below, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under these policies. These CARC/RARC combinations compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: shown below.
MSN: N/A

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

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

    b. If a "Yes" or "No" is not indicated in item 20 and an acquisition price is entered under the word "$CHARGES." *RARC: MA110*

    c. If the "YES" box is checked in item 20 and a required acquisition price is not entered under the word "$CHARGES." *RARC: MA111*

    d. If the "NO" box is checked in item 20 and an acquisition price is entered under the word "$CHARGES." *RARC: MA110*

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

    Entries f – k are effective for claims received on or after April 1, 2004:

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

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

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

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

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

k. If there is an indication on the claim that the test is subject to anti-markup and the NPI of the performing entity (in Item 32a of the CMS-1500 or its ASC X12 837 equivalent) belongs to the billing provider OR the performing entity is not a valid, Medicare enrolled entity.

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

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

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

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

7. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. *Item 4: RARC: MA92. Item 6: RARC: MA89. Item 7: RARC: MA88.*

8. If there is insurance primary to Medicare that is indicated in item 11 by either an insured/group policy number or the Federal Employee Compensation Act number, but a Payer or Plan identification number (use HPID when effective) is not entered in field 11C *(RARC: MA92)*, or the primary payer's program or plan name when a Payer or Plan ID (use HPID when effective) does not exist *(RARC: N245).*

9. If a HCPCS code modifier must be associated with a HCPCS procedure code or if the HCPCS code modifier is invalid or obsolete. *RARC: M20*

10. If a date of service extends more than 1 day and a valid "to" date is not present in item 24A. *RARC: M59*

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

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

    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. *RARC: MA114*

    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. *RARC: MA114*

    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. *RARC: MA114*

    Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the ASC X12 837 professional electronic claim format 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. *RARC: MA114*

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

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

The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 4
RARC: N/A
MSN: N/A

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

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

Unless otherwise specified, the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under the policies in this section. These CARC/RARC combinations compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 16
RARC: shown below.
MSN: N/A

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

A. For chiropractor claims:

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

2. If the initial date "actual" treatment occurred is not entered in item 14. *RARC: MA122*

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. *RARC: MA112*

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. *RARC: MA114*

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 into item 24J of the Form CMS-1500. *RARC: N290*

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. *RARC: MA114.* 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 *(RARC: N324)* and the attending physician's NPI is not present in item 19 *(RARC: N253)*.

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. *(RARC: N264)*, or if the NPI is not entered in item 17b. of the Form CMS-1500 *(RARC: N286)*.

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. *(RARC: N264)* or if the NPI is not entered in item 17b. of the Form CMS-1500 *(RARC: N286)*.

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. *RARC: MA114* 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"). *RARC: MA116*

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. *RARC: MA114.* 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 an anti-markup service and the service is purchased from another billing jurisdiction, the billing physician or supplier must submit the name, address, and ZIP Code of the performing physician or supplier in Item 32, and the NPI of the performing physician or supplier in Item 32a. If Items 32 and 32a are not entered. *RARC: MA114*

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. *RARC: MA128*

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 *(RARC: N264)* or if the NPI is not entered in item 17b. of the Form CMS-1500*(RARC: N286)*.

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 *(RARC: N264)* or if the NPI is not entered in item 17b. of the Form CMS-1500 *(RARC: N286)*.

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 item 17 *(RARC: N264)* or if the NPI is not entered in item 17b. of the Form CMS-1500 *(RARC: N286)*.

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, 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.

For item N only: The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 183
RARC: N574
MSN: N/A

The claim is denied *when the first four letters of the last name provided on the ordering/referring provider's claim does not match what is listed in the provider's record. RARC: N264*

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. This is the only instance when a rejection is allowed. *RARC: N256.*

O. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP Code for 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. *RARC: 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. *RARC: MA120*

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. *RARC: MA50*. 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.

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

T. For claims for artificial hearts covered by Medicare under an approved clinical trial, if procedure code 0051T is entered in Item 24D, and an 8-digit clinical trial number that matches an approved clinical trial listed at: http://www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp#TopOfPage is not entered in Item 19; and the HCPCS modifier Q0 is not entered on the same line as the procedure code in Item 24D, and the diagnosis code V70.7 (if ICD-9-CM is applicable) or Z00.6 (if ICD-10-CM is applicable) is not entered in Item 21 and linked to the same procedure code.

For item T only: The contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two.

Group Code: CO
CARC: 4
RARC: N/A
MSN: N/A

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

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

Medicare Claims Processing Manual
Chapter 16 - Laboratory Services

10.2 - General Explanation of Payment
(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

Outpatient laboratory services can be paid in different ways:

- Physician Fee Schedule;
- 101 percent of reasonable cost (critical access hospitals (CAH) only);

NOTE: When the CAH bills a 14X bill type for a non-patient laboratory specimen, the CAH is paid under the fee schedule.

- Laboratory Fee Schedule;
- Outpatient Prospective Payment System, (OPPS) except for most hospitals in the State of Maryland that are subject to a waiver; or
- Reasonable Charge

Annually, CMS distributes a list of codes and indicates the payment method. Carriers, FIs, and A/B MACs pay as directed by this list. Neither deductible nor coinsurance applies to HCPCS codes paid under the laboratory fee schedule. The majority of outpatient laboratory services are paid under the laboratory fee schedule or the OPPS.

Carriers, FIs and A/B MACs are responsible for applying the correct fee schedule for payment of clinical laboratory tests. FIs/AB MACs must determine which hospitals meet the criteria for payment at the 62 percent fee schedule. Only sole community hospitals with qualified hospital laboratories are eligible for payment under the 62 percent fee schedule. Generally, payment for diagnostic laboratory tests that are not subject to the clinical laboratory fee schedule is made in accordance with the reasonable charge or physician fee schedule methodologies (or at 101 percent of reasonable cost for CAHs).

For Clinical Diagnostic Laboratory services denied due to frequency edits, *the contractor shall use the following remittance advice messages and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.*

Group Code: CO or PR
CARC: 151
RARC: N/A
MSN: N/A

50.2.1 - Assignment Required
(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

Carriers must:

- Pay for clinical laboratory services provided in the physician's office only on an assignment basis.
- Treat as assigned any claims for clinical laboratory services provided in the physician's office even if the claimant submits the claim on a non-assigned basis or if the assignment option is not designated.

- Deny claims where it is apparent from the claims form or from other evidence that the beneficiary or provider refuses to assign.

The contractor shall use the following remittance advice message and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO or PR
CARC: 111
RARC: N/A
MSN: 16.41 OR 16.6

70.10.1 - Physician Notification of Denials

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

If there is no CLIA number on the claim, *the contractor shall use the following remittance advice message and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Two*

Group Code: CO or PR
CARC: 16
RARC: MA120
MSN: N/A

70.11 - Reasons for Denial - Physician Office Laboratories Out-of-Compliance

(Rev. 3510, Issued: 04-29-16, Effective: 10-01-16, Implementation; 10-03-16)

The contractor shall use the following remittance advice message and associated codes when rejecting/denying claims under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: B7
RARC: N/A
MSN: 14.1