CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1187	**Date: FEBRUARY 23, 2007**
	Change Request 5391

SUBJECT: Revisions to Incomplete or Invalid Claims Instructions Necessary to Implement the Revised Health Insurance Form CMS-1500(8/05)

I. SUMMARY OF CHANGES: Revises the Medicare Claims Processing manual instruction sections related to handling incomplete and invalid claims to reflect the changes in reporting items for the NPI on the revised Form CMS-1500(08/05). Updates references to remark codes. Revises the instructions related to the searching of contractor's internal files to remedy certain missing or incomplete claims data on submitted claims. Note: Although the effective and implementation date for the rest of CR5391 is May 23, 2007, contractors may end certain searching of internal files sooner, i.e., 30 days after the issuance date of this Change Request.

New / Revised Material
Effective Date: Claims received on or after May 23, 2007
Implementation Date: May 23, 2007

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	1/80.3.2.1.1/Carrier Data Element Requirements
R	1/80.3.2.1.2/Conditional Data Element Requirements for Carriers and DMERCs
R	1/80.3.2.1.3/Carrier Specific Requirements for Certain Specialties/Services

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1187	Date: February 23, 2007	Change Request:5391

SUBJECT: Revisions to Incomplete or Invalid Claims Instructions Necessary to Implement the Revised Health Insurance Form CMS-1500(8/05)

Effective Date: Claims received on or after May 23, 2007

Implementation Date: May 23, 2007

NOTE: Although the implementation date for the rest of CR 5391 is May 23, 2007, contractors may implement business requirement 5391.4 sooner for claims received on or after 30 days from the issuance date of this Change Request.

I. GENERAL INFORMATION

A. Background: The Form CMS-1500 has been revised to accommodate the reporting of the National Provider Identifier (NPI). The revised form is designated as Form CMS-1500 (8/05). The revisions include additional items for the reporting of the NPI. The revisions also include items that have already been implemented through the Competitive Acquisition of Part B Drugs and Biologicals (CAP) CRs 4064, 4306, 4309, 5079, and 5259.

B. Policy: As a result of the revisions to the Form CMS-1500 (8/05), the incomplete and invalid claims instructions need to be updated to reflect the appropriate items in which the NPI will be reported. In order to be consistent with NPI and HIPAA requirements, contractors are directed not to search their internal files to remedy missing or incorrect NPIs or HIPAA required data. Additionally, the instruction is changed to update remark codes to be used when incomplete claims are returned as unprocessable.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5391.1	Contractors shall make all necessary changes to your internal business processes to enable the return of claims as unprocessable that do not report an NPI when required in a provider name segment or another provider identification segment in an electronic or a CMS-1500 (08/05) paper claim. See the Medicare	X	X		X	X						

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	Claims Processing Manual, Chapter One, (Pub. 100-04), Chapter One, Sections 80.3.2.1.1 through 80.3.2.1.3 and the Health Care Claim Professional 837 Implementation Guide for further information.											
5391.2	Contractors shall use the appropriate remittance advice remark codes provided in the Medicare Claims Processing Manual, Chapter One, (Pub. 100-04), Chapter One, Sections 80.3.2.1.1 through 80.3.2.1.3, when returning claims as unprocessable.	X	X		X	X						
5391.3	Contractors shall not search their internal files to correct a missing or inaccurate NPI on a Form CMS-1500(8/05) or on an electronic claim.	X	X		X	X						
5391.4	**NOTE:** Although the implementation date for the rest of CR 5391 is May 23, 2007, contractors may implement business requirement 5391.4 sooner for claims received on or after 30 days from the issuance date of this Change Request. Contractors shall not search their internal files to correct missing or inaccurate required or conditional data elements required by Medicare Claims Processing Manual (Pub. 100-04), Chapter One, Sections 80.3.2.1.1 through 80.3.2.1.3, and required for HIPAA compliance for claims governed by HIPAA.	X	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5391.5	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X	X						

IV. SUPPORTING INFORMATION

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

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

B. For all other recommendations and supporting information, use the space below: N/A

V. CONTACTS

Pre-Implementation Contact(s): Thomas Dorsey, 410-786-7434, Thomas.Dorsey@cms.hhs.gov

Post-Implementation Contact(s): Appropriate CMS Regional Office

VI. FUNDING

A. ***For TITLE XVIII Contractors:***

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. ***For Medicare Administrative Contractors (MAC):***

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

80.3.2 - Handling Incomplete or Invalid Claims

(Rev.1187, Issued: 02-23-07, Effective: 05-23-07, Implementation: 05-23-07)

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 should 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.
- 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" new 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 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.
- If a beneficiary submits a claim with incomplete or invalid information, the carrier or FI suspends and develops the claim. If corrections are not received within the suspense period, or if corrections are inaccurate, then the carrier or FI denies the claim and affords appeal rights.

NOTE: Telephone inquiries are encouraged.

- The carrier or FI will 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 if an NPI is missing or inaccurate. 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 five 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 list some exceptions when a claim may not be "returned as unprocessable" for incomplete or invalid information.

Carriers 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.)

80.3.2.1.1 - Carrier Data Element Requirements

(Rev.1187, Issued: 02-23-07, Effective: 05-23-07, Implementation: 05-23-07)

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. Use remark code *N329* on the remittance advice. For formats other than the remittance, use code(s)/messages that are consistent with the above remark codes.

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 11*a.*, 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.

Carriers must return claims as unprocessable if they do not adhere to these requirements.

2 - Electronic Claims

Carriers must return all electronic claims that do not include an 8-digit date (CCYYMMDD) when a date is reported. They use remark code *N329* on the remittance advice. For formats other than the remittance, carriers use code(s)/message(s) that are consistent with the above remark codes.

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 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, effective May 23, 2007 (effective May 23, 2008 for small health plans). Although not required by HIPAA, CMS is extending the requirement in include the NPI on electronic claims to paper claims submitted on the Form CMS-1500 (8/05). Carriers are referred to the Health Care Claims Professional 837 Implementation guide for requirements for professional claims subject to HIPAA, including the NPI reporting requirements.*

Carriers must return a claim as unprocessable to a provider of service or supplier and use the indicated remark codes if the claim is returned through the remittance advice or notice process. In most cases, reason code 16, "Claim/service lacks information that is needed for adjudication", will be used in tandem with the appropriate remark code that specifies the missing information. Carriers use the following:

1. If a claim lacks a valid Medicare Health Insurance Claim Number (HICN) in item 1*a*. or contains an invalid HICN in item 1*a*. (Remark code MA61.)
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. (Remark code MA36.)
3. If a claim does not indicate in item 11 whether or not a primary insurer to Medicare exists. (Remark code MA83 or MA92.)
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. Remark code MA75.)

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. (Remark code M52.)
6. If a claim lacks a valid place of service (POS) code in item 24B., or contains an invalid POS in item 24B. return the claim as unprocessable to the provider or supplier, using RA remark code M77. 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.
7. If a claim lacks a valid procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D or contains an invalid or obsolete procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D. (Remark code M20 or M51.)

NOTE: Level 3 HCPCS will be going away with HIPAA.

8. If a claim lacks a charge for each listed service. (Remark code M79.)
9. If a claim does not indicate at least one day or unit in item 24G *(Remark Code M53.)* (**Note:** To avoid returning the claim as "unprocessable" when the information in this item is missing, the *Carrier* must program the system to automatically default to "1" unit).
10. If a claim lacks a signature from a provider of service or supplier, or their representative. (See "Exceptions," bullet number one; Remark code MA70 for a missing provider representative signature, or code MA81 for a missing physician/supplier/practitioner signature.)
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. (Remark code *N256* or *N258*.)

    AND EITHER

    b. A valid PIN number or, for DMERC claims, a valid National Supplier Clearinghouse number *(NPI in item 33a. of the CMS-1500 (8/05) when the NPI is effective)* for the performing provider of service or supplier who is not a member of a group practice. (Remark code *N257*)

    OR

    c. A valid group PIN (or NPI when effective) number or, for DMERC claims, a valid National Supplier Clearinghouse number *(NPI in item 33a. of the CMS-1500 (8/05) when the NPI is effective)* for performing providers of service or suppliers who are members of a group practice. (Remark code *N257*)

12. If a claim does not contain in Item 33a., Form CMS 1500 (08-05), on or after May 23, 2007, the NPI of the billing provider, supplier, or group. (Remark Code N257 or MA112.)

80.3.2.1.2 - Conditional Data Element Requirements for Carriers and DMERCs

(Rev.1187, Issued: 02-23-07, Effective: 05-23-07, Implementation: 05-23-07)

A - Universal Requirements

The following instruction describes "conditional" data element requirements, which are applicable to assigned carrier claims. This instruction is minimal and does not include all "conditional" data element requirements, which are universal for processing claims. The CMS has specified which remark code(s) should be used when a claim fails a particular "return as unprocessable" edit and a remittance advice is used to return the claim. In addition to the specified remark code(s), carriers must include Remark Code MA130 on returned claim(s). Reason code(s) must also be reported on every remittance advice used to return a claim or part of a claim as unprocessable.

Items from the Form CMS-1500 (hardcopy) have been provided. These items are referred to as fields in the instruction. A crosswalk between Form CMS-1500 items and records and fields on the NSF can be found in Exhibit 1.

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

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 UPIN (NPI when effective) is not present in item 17 or 17a. *or if the NPI is not entered in item 17b. of the CMS-1500 (8/05) when the NPI is effective.* (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 UPIN *(NPI when effective)* of the supervising physician is not entered in items 17 or 17a.

(Remark code *N269* or *N270* is used.)

c. For diagnostic tests subject to purchase price limitations:

    1. If a "YES" or "NO" is not indicated in item 20. (Remark code M12 is used.)
    2. If the "YES" box is checked in item 20 and the purchase price is not entered under the word "$CHARGES." (Remark code MA111 is used.)
    3. If the "YES" box is checked in item 20 and the purchase price is entered under "$CHARGES", but the supplier's name, address, ZIP code, and PIN are not entered in item 32 *or if the NPI is not entered into item 32a. of the CMS-1500 (8/05) when the NPI is effective* when billing for purchased diagnostic tests. (Remark code *N256, N257, or N258 are* used.)

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

    4. On the Form CMS-1500, if the "YES" box is checked in Item 20, and more than one test is billed on the claim;
    5. On the Form CMS-1500, if both the interpretation and test are billed on the same claim and the dates of service and places of service do not match;

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

7. On the ANSI X12N 837 electronic format, if there is an indication on the claim that a test has been purchased, more than one test is billed on the claim, and line level information for each total purchased service amount is not submitted for each test.

8. On the Form CMS-1500 if the "YES" box is checked in Item 20 and on the ANSI X12N 837 electronic format if there is an indication on the claim that a test has been purchased, and the service is billed using a global code rather than having each component billed as a separate line item.

d. If a provider of service or supplier is required to submit a diagnosis in item 21 and either an ICD-9CM code is missing, incorrect or truncated; or a narrative diagnosis was not provided on an attachment. (Remark code M81 *or M76 are* used.)

e. If modifiers "QB" and "QU" *or, effective on or after 1/1/2006, the modifier "AQ"* are entered in item 24D indicating that the service was rendered in a Health Professional Shortage Area, but where the place of service is other than the patient's home or the physician's office, the name, address, and ZIP code of the facility where the services were furnished are not entered in item 32. (Remark code MA115 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.

f. If a performing physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner is a member of a group practice and does not enter his or her PIN in item 24K *or if the NPI is not entered into item 24J of Form CMS-1500 (08-05) when the NPI is effective* and the group practice's PIN (or NPI when effective) in item 33. (Remark code MA112 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 one 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.

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 in item 32.

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services

(Rev.1187, Issued: 02-23-07, Effective: 05-23-07, Implementation: 05-23-07)

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

a. For chiropractor claims:

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

2. If the initial date “actual” treatment occurred is not entered in item 14. (Remark code MA122 is used.)

b. For certified registered nurse anesthetist (CRNA) and anesthesia assistant (AA) claims, if the CRNA or AA is employed by a group (such as a hospital, physician, or ASC) and the group’s name, address, ZIP code, and PIN number is not entered in item 33 *or if the NPI is not entered in item 33a. of the CMS-1500 (8/05) when the NPI is effective* or their personal PIN is not entered in item 24K *(if the NPI is not entered into item 24J of the CMS-1500 (8/05) when the NPI is effective)*. (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 attending physician’s PIN is not entered in item 24K *or if the NPI is not entered into item 24J of the CMS-1500 (8/05) when the NPI is effective).* (Remark code *N290* is used.)

2. If the name, address, and ZIP code of the facility other than the patient's home or physician's office involved with the patient's maintenance of care and training is not entered in item 32. (Remark code MA114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 must be entered.

e. For routine foot care claims, if the date the patient was last seen and the attending physician's PIN (or NPI when effective) 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 and/or UPIN (or NPI when effective) is not present in items 17 or 17a. *or if the NPI is not entered in item 17b. of the CMS-1500 (8/05) when the NPI is effective.* (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 and/or UPIN (or NPI when effective) is not present in items 17 or 17a. *or if the NPI is not entered in item 17b. of the CMS-1500 (8/05) when the NPI are effective).* (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.

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 and/or UPIN (or NPI when effective) is not present in items 17 or 17a. *or if the NPI is not entered in item 17B of the Form CMS-1500 (8/05) when the NPI is effective).* (Remark code *N264 or N286* is used.)

l. For portable x-ray services claims, if the ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name, and/or UPIN (or NPI when effective) are not entered in items 17 or 17a. or *if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is effective).* (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, clinical nurse specialist's name, and/or UPIN (or NPI when effective) if appropriate are not entered in items or 17a. *or if the NPI is not entered in item 17B of the Form CMS-1500 (8/05) when the NPI is effective*. (Remark code *N264 or N286* is used.)

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

1. If the UPIN (or NPI when effective) of the attending physician is not present in item 19. (Remark code *N253* is used.)
2. If the 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) date patient was last seen by the attending physician is not present in item 19. (Remark code *N324* is used.)

o. For all laboratory work performed outside a physician's office, if the claim does not contain a name, address, and ZIP code, and PIN where the laboratory services were performed in item 32 of the NPI is not entered *or if the NPI is not entered into item 32a. of the Form CMS-1500 (8/05) when the NPI is effective)*, 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 MA*120* 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. (Remark code MA50 is used.)

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 100.4.2 through 100.4.4.