CMS Manual System	Department of Health & Human Services
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services
Transmittal 1903	**Date: January 29, 2010**
	Change Request 6670

Transmittal 1842, dated October 30, 2009, is being rescinded and replaced by Transmittal 1903, dated January 29, 2010, to include subsection 80.3.2.1.2, letter "n". Transmittal 1867 (CR 6718) dated December 12, 2009 and Transmittal 1842 (CR 6670) both revised subsection 80.3.2.1.2. During these revisions, there was an oversight which caused the letter "n" which was added by CR 6718 to be omitted from CR 6670. All other material remains the same.

SUBJECT: Instructions for Processing Claims Containing Anti-Markup Services but with Partial Information Completed in Item 20 of the Form CMS-1500

I. SUMMARY OF CHANGES: This transmittal gives instructions for processing claims for diagnostic services that are subject to the anti-markup payment limitation and that are billed with missing or incomplete information in Item 20 of the Form CMS-1500 or its electronic equivalent. Contractors shall apply specific criteria for determining whether to process a claim containing diagnostic services when Item 20 is partially completed.

New / Revised Material
Effective Date: April 1, 2010
Implementation Date: April 5, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	1/80.3.2.1.2/Conditional Data Element Requirements for A/B MACs and DMEMACs

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1903	Date: January 29, 2010	Change Request: 6670

Transmittal 1842, dated October 30, 2009, is being rescinded and replaced by Transmittal 1903, dated January 29, 2010, to include subsection 80.3.2.1.2, letter "n". Transmittal 1867 (CR 6718) dated December 12, 2009 and Transmittal 1842 (CR 6670) both revised subsection 80.3.2.1.2. During these revisions, there was an oversight which caused the letter "n" which was added by CR 6718 to be omitted from CR 6670. All other material remains the same.

SUBJECT: Instructions for Processing Claims Containing Anti-Markup Services but with Partial Information Completed in Item 20 of the Form CMS-1500

Effective Date: April 1, 2010

Implementation Date: April 5, 2010

I. GENERAL INFORMATION

A. Background:

Publication 100-04, chapter 1, §80.3.2.1.2 establishes guidelines for processing of claims for diagnostic services when there is no entry for the "Yes/No" indicator in Item 20 of the Form CMS-1500 or the ANSI X12 837P electronic claim is missing a claim or line level PS1 segment to indicate whether the diagnostic services were purchased. Contractors are instructed to assume that a diagnostic service was not purchased when there is no "Yes/No" indicator marked in Item 20 of the paper claim form or its electronic equivalent. Additionally, the instructions referred to what was formerly known as "purchased diagnostic tests" and applied only to the technical component (TC) of a diagnostic test. (See Transmittal 1589)

This Transmittal gives instructions for processing claims for diagnostic services that are subject to what is now known as the anti-markup payment limitation and that are billed with missing or incomplete information in Item 20 of the Form CMS-1500 or its electronic equivalent.

B. Policy:

Contractors shall use the following guidelines for determining whether a claim contains a diagnostic service that is subject to the anti-markup payment limitation: (Note: These guidelines apply to both the Form CMS-1500 and its electronic equivalent).

- If a "Yes" or "No" is not indicated in Item 20 and the associated dollar amount is missing, contractors shall assume the service is not subject to the anti-markup payment limitation and shall process the claim accordingly.
- If a "Yes" or "No" is not indicated in Item 20 and the associated dollar amount is present, contractors shall return the claim as unprocessable.
- If the "Yes" box is marked in Item 20 and the associated dollar amount is missing, contractors shall return the claim as unprocessable.
- If the "No" box is marked in Item 20 and the associated dollar amount is present, contractors shall return the claim as unprocessable.

In accordance with the requirements of the anti-markup payment limitation, contractors shall apply the aforementioned logic to both the TC and PC (professional component) of diagnostic tests.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6670.1	Contractors shall assume a diagnostic service is not subject to the anti-markup payment limitation when neither "Yes" nor "No" is marked in Item 20 and the associated dollar amount is missing.	X			X						
6670.2	Contractors shall return as unprocessable claims submitted with a dollar amount but without a "YES" or "No" marked in Item 20.	X			X						
6670.2.1	Contractors shall use Reason Code 16 ("Claim/service lacks information which is needed for adjudication") and RA Remark Code MA110 ("Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.") when returning a claim as unprocessable according to BR 6670.2.	X			X						
6670.3	Contractors shall return as unprocessable claims submitted with a "YES" marked in Item 20 but no dollar amount in Item 20.	X			X			X			
6670.3.1	Contractors shall use Reason Code 16 ("Claim/service lacks information which is needed for adjudication") and RA Remark Code MA111 ("Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.") when returning a claim as unprocessable according to BR 6670.3.	X			X						
6670.4	Contractors shall return as unprocessable claims submitted with a "No" and a dollar amount is indicated in Item 20.	X			X						
6670.4.1	Contractors shall use Reason Code 16 ("Claim/service lacks information which is needed for adjudication") and RA Remark Code MA110 ("Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.") when returning a claim as unprocessable according to BR 6670.4.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6670.5	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. 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						

IV. SUPPORTING INFORMATION

Section 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

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

V. CONTACTS

Pre-Implementation Contact(s): Felicia Rowe, (410) 786-5655 or by email at Felicia.Rowe@cms.hhs.gov

Post-Implementation Contact(s): Felicia Rowe, (410) 786-5655 or by email at Felicia.Rowe@cms.hhs.gov

VI. FUNDING

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

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

Section B: ***For Medicare Administrative Contractors (MACs)*****:**

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

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents
(Rev. 1903, 01-29-10)

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

(Rev. 1903, Issued: 01-29-10, Effective: 04-01-10, Implementation: 04-05-10)

A - Universal Requirements

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

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

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

a. If a service was ordered or referred by a physician, physician assistant, nurse practitioner, or clinical nurse specialist (other than those services specified in Claim Specific Requirements) and his/her name and/or NPI is not present in item 17 or 17a or if the NPI is not entered in item 17b of the Form CMS-1500 (8/05). (Remark code N285 or N286 is used)

b. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or NPI is required of the supervising physician is not entered in items 17 or 17a or if the NPI is not entered in item 17b of the Form CMS-1500 (8/05). (Remark code N269 or N270 is used.)

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

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

    2. *If a "Yes" or "No" is not indicated in item 20 and an acquisition price is entered under the word "$CHARGES." (Remark Code MA110 is used.)*

    3. If the "YES" box is checked in item 20 and a required *acquisition* price is not entered under the word "$CHARGES." (Remark code MA111 is used.)

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

5. If the "YES" box is checked in item 20 and the *acquisition* price is entered under "$CHARGES", but the *performing physician or other* supplier's name, address, ZIP Code, *and* NPI is not entered into item 32a of the Form CMS-1500 (8/05) when billing for diagnostic *services subject to the anti-markup payment limitation*. (Remark code *N294 is* used.)

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

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

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

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

7. On the ANSI X12N 837 electronic format, if there is an indication on the claim that a test *is subject to the anti-markup payment limitation*, more than one test is billed on the claim, and line level information for each total *acquisition* amount is not submitted for each test.

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

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

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

f. If a rendering physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner who is a sole practitioner or is a member of a group practice does not enter his/her NPI into item 24J of Form CMS-1500 (08-05) except for influenza virus and pneumococcal vaccine claims submitted on roster bills that do not require a rendering provider NPI. (Remark code N290 is used.)

g. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. (Remark code(s) MA64, MA88, MA89, or MA92 as appropriate for the missing piece(s) of data are used.)

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

i. If a HCPCS code modifier must be associated with a HCPCS procedure code or if the HCPCS code modifier is invalid or obsolete. (Remark code M20 if there is a modifier but no HCPCS.)

j. If a date of service extends more than 1 day and a valid "to" date is not present in item 24A. (Remark code M59 is used.)

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

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

Effective for claims with dates of service on or after October 1, 2007, the name, address, and 9-digit ZIP Code of the service location for services paid under the Medicare Physician Fee Schedule and anesthesia services, other than those furnished in place of service home – 12, and any other places of service *A/B MACs* treat as home, must be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1. (Remark code MA114 is used.)

Effective for claims with dates of service on or after October 1, 2007, for claims received that require a 9-digit ZIP Code with a 4 digit extension, a 4-digit extension that matches one of the ZIP9 file or a 4-digit extension that can be verified according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 must be entered on the claim. (Remark code MA114 is used.)

m. Effective for claims received on or after April 1, 2004, if more than one name, address, and ZIP Code is entered on the Form CMS-1500 (08-05) in item 32.

n. If any of the modifiers PA, PB, or PC are incorrectly associated with a service which is other than a wrong surgery on a patient, surgery on the wrong body part, surgery on the wrong patient or a service related to one of these surgical errors. (Claim Adjustment Reason Code 4 is used.)