CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3047	**Date: August 22, 2014**
	Change Request 8806

SUBJECT: Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims

I. SUMMARY OF CHANGES: This Change Request (CR) provides guidance for physicians and suppliers billing anti-markup and reference laboratory claims. Physicians and other suppliers will no longer be permitted to submit their own NPI in Item 32a (or its electronic equivalent) when the performing physician or supplier is located in another jurisdiction. The changes that will be implemented in PECOS will allow contractors the ability to verify all physician and supplier NPIs, regardless of the jurisdiction in which they are enrolled.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015 - For claims received on and after January 1, 2015

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	1/10.1.1.2 /Payment Jurisdiction for Services Subject to the Anti-Markup Payment Limitation
R	1/ 30.2.9 /Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation - Claims Submitted to A/B MACs
R	1/30.3.7/Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) Subject to the Anti-Markup Payment Limitation - Claims
R	1/80.3.2.1.2/ Conditional Data Element Requirements for A/B MACs and DMEMACs
R	1/ 80.3.2.1.3 /Carrier Specific Requirements for Certain Specialties/Services
R	16/40.1.1.1 / Paper Claim Submission To Carriers/B MAC
R	16/40.1.1.2 /Electronic Claim Submission to Carriers/B MAC
R	26/10.4 / Items 14-33 - Provider of Service or Supplier Information
R	35/ 30 / Diagnostic Tests Subject to the Anti-Markup Payment Limitation

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 obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3047	Date: August 22, 2014	Change Request: 8806

SUBJECT: Reporting the Service Location National Provider Identifier (NPI) on Anti-Markup and Reference Laboratory Claims

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 5, 2015 - For claims received on and after January 1, 2015

I. GENERAL INFORMATION

A. Background: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all covered health care entities follow the same standard for submitting and processing electronic claims transactions. According to the instructions for use of the American National Standards Institute (ANSI) X12 837 professional electronic claim transaction, suppliers must submit the NPI that matches the name and address of the servicing provider/supplier identified on the claim.

On anti-markup and reference laboratory claims, physicians and other suppliers are required to identify the supplier's name, address, and ZIP code in Item 32 of the CMS-1500 claim, or the corresponding loop and segment of the (ANSI) X12 837 professional electronic claim format. The NPI of the physician or supplier who actually performed the service is required in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the (ANSI X12 837 professional electronic claim transaction.

However, prior to the implementation of the Provider Enrollment Chain of Ownership System (PECOS), contractors used enrollment systems that were specific to each Medicare contractor and did not allow Medicare contractors from one State to view provider enrollment information from another State. This systems limitation prevented contractors from being able to share information about existing providers/suppliers, and increased the potential for fraud.

As a result, physicians and suppliers that were enrolled in another contractor’s jurisdiction could not validate the NPI in Item 32a of the CMS-1500 claim form or on the ANSI X12 837 professional electronic claim format, because the function was not available in PECOS.

Since the NPI of the physician/supplier that actually performed the test may not be available to the billing physician or supplier, the claims processing Internet Only Manual at Publication 100-04 currently instructs physicians and suppliers to submit their own NPI with the name and address of the actual performing physician or supplier in Item 32a (and its electronic equivalent) when billing for reference laboratory services, or services subject anti-markup, when the performing physician or supplier is enrolled in another contractor’s jurisdiction.. Effective January 1, 2015, changes will be implemented in PECOS to allow contractors the ability to verify all physician and supplier NPIs, regardless of the jurisdiction in which they are enrolled. Therefore, beginning January 1, 2015, physicians and suppliers billing anti-markup and reference laboratory claims must report the NPI of the physician or supplier who actually performed the service in Item 32a of the CMS-1500 claim form or the corresponding loop and segment of the American National Standards Institute (ANSI) X12 837 professional electronic claim format. This new requirement applies to all claims, including claims for services where the performing physician/supplier is out of the processing contractor’s jurisdiction.

B. Policy: Effective for anti-markup and reference laboratory claims submitted with a receipt date on or after January 1, 2015, billing physicians and suppliers are required to report the name, address, ZIP code, and NPI of the performing physician or supplier when the performing physician or supplier is enrolled in a different contractor’s jurisdiction. Physicians and other suppliers will no longer be permitted to submit their

own NPI in Item 32a (or its electronic equivalent) when the performing physician or supplier is located in another jurisdiction. Contractors shall validate the entity identified in Item 32 (or its electronic equivalent) on all claims for reference lab and anti-markup services performed both in and out of jurisdiction. Contractors shall return as unprocessable any inbound CMS-1500 claim form, or ANSI X12 837 professional electronic claim transaction with an NPI in Item 32a (or its electronic equivalent) that belongs to the billing physician/supplier or that cannot be verified as a valid, Medicare-enrolled entity.

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	
8806.1	Contractors shall apply the requirements in this change request to anti-markup and reference laboratory claims only.		X				X			
8806.1.1	Contractors shall identify anti-markup claims by the presence of the 'Yes' indicator in Item 20 of the CMS-1500 or its electronic equivalent (loop 2400 PS102 of the 837 professional claim).		X							
8806.1.2	Contractors shall identify reference laboratory claims by the presence of modifier 90 on any service line.		X							
8806.2	Contractors shall return as unprocessable a claim for a reference laboratory or anti-markup service when physicians and suppliers submit their own NPI, rather than the NPI of the performing physician/supplier in Item 32a of the CMS-1500 claim form, or on the ANSI X12 837 professional electronic claim format (loops 2310C NM109 claim level and 2420C NM109 line level).		X				X			
8806.3	Contractors shall verify that the NPI in Item 32a (or its electronic equivalent) matches the NPI of a valid entity via the new table located in MCS' internal claims processing system.		X				X			
8806.3.1	PECOS shall provide a format of the file to MCS. The file will consist of the following data elements: 1. NPI, 2. Physician/supplier name, 3. Legal business name, 4. DBA name,									PECOS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	5. CMS specialty code and description, 6. PIN effective and termination date, and 7. Filler									
8806.3.2	MCS shall accept an extract file from the PECOS system on a daily basis.						X			PECOS
8806.4	Contractors shall return as unprocessable a claim for a reference laboratory or anti- markup service when the NPI in Item 32A (or its electronic equivalent) does not match a valid servicing physician/supplier identified on the existing table in PECOS located via the MCS internal claims processing system.		X				X			
8806.5	Contractors shall use the following codes for claims returned as unprocessable: Claim Adjustment Reason Code (CARC) 16 - Claim/service lacks information which is needed for adjudication. For reference lab claims, use Remittance Advice Remark Code (RARC) N270 - Missing / incomplete / invalid other provider primary identifier. For anti-markup claims, use RARC N283 - Missing / incomplete / invalid purchased service provder identifier. Group Code: Contractual Obligation (CO)		X							
8806.6	MCS shall maintain the ability for contractors to manually key the facility NPI for claims submitted on the CMS-1500.						X			

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility		
		A/B MAC	DME	CED

		A	B	H H H	M A C	I
8806.7	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 one week of the availability of the provider education 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			

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:
8806.3.1	PECOS file is included.

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

V. CONTACTS

Pre-Implementation Contact(s): Teira Canty, Teira.Canty@cms.hhs.gov

Post-Implementation Contact(s): Contact your regional Coordinator.

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: 1

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

10.1.1.2 - Payment Jurisdiction for Services Subject to the Anti-Markup Payment Limitation

(Rev.3047, Issued: 08-22-14, Effective: 01-01-15, Implementation 01-05-15)

Diagnostic tests and their interpretations are paid on the MPFS. Therefore, they are subject to the same payment rules as all other services paid on the MPFS. Additional explanation is provided here due to general confusion concerning these services when they are performed or supervised by a physician or other supplier who does not meet the criteria for "sharing a practice" with the billing physician or other supplier, rather than rendered and billed by the billing entity. (See §30.2.9 for additional information on "sharing a practice.") Physicians and other suppliers must meet the current enrollment criteria stated in chapter 10, of the Program Integrity Manual, in order to be able to bill for anti-markup tests. That these services are billed by an entity that does not share a practice with the performing physician or other supplier does not negate the need for the performing physician or other supplier to follow appropriate enrollment procedures with the B/MAC that has jurisdiction over the geographic area where the services were rendered.

The B/MACs must accept and process claims for services subject to the anti-markup payment limitation when billed by physicians or other suppliers enrolled in the B/MAC's jurisdiction, regardless of the location where the services were furnished.

Effective for claims processed on or after April 1, 2004, in order to allow the B/MAC to determine jurisdiction and apply the anti-markup payment limitation correctly, global billing will not be accepted on electronic or paper claims when billing anti-markup tests. Claims received with global billings in this situation will be treated as unprocessable per §80.3.

Effective for claims submitted with a receipt date on and after January 1, 2015, billing physicians and suppliers must report the name, address, and NPI of the performing physician or supplier on all anti-markup and reference laboratory claims, even if the performing physician or supplier is enrolled in a different contractor's jurisdiction. Contractors shall return as unprocessable any anti-markup or reference laboratory claim with an NPI in Item 32a (or its electronic equivalent) that belongs to the billing physician/supplier, or that cannot be verified as a valid, Medicare enrolled entity.

A. Payment Jurisdiction for Suppliers of Diagnostic Tests and Interpretations Performed by Other Suppliers under Contract

Effective for claims with dates of service on or after January 25, 2005, laboratories, physicians, and IDTFs must submit all claims for anti-markup tests to their local B/MAC. B/MACs must accept and process claims for services subject to the anti-markup payment limitation when billed by suppliers enrolled in the B/MAC's jurisdiction, regardless of the location where the services were furnished. B/MACs should allow claims submitted by an IDTF for anti-markup tests if the IDTF has previously enrolled to bill for anti-markup test components they perform.

Effective April 1, 2005, B/MACs must price anti-markup tests billed by laboratories and IDTF's based on the ZIP code of the location where the diagnostic test was rendered.

Effective for claims with dates of service on or after October 1, 2007, B/MACs must use the national abstract file to price all claims for anti-markup tests for all supplier specialty types (including physicians), based on the ZIP code of the location where the service was rendered.

30.2.9 - Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation - Claims Submitted to A/B MACs

(*Rev.3047, Issued: 08-22-14, Effective: 01-01-15, Implementation 01-05-15*)

A physician or other supplier may bill for the technical component (TC) and/or professional component (PC) of a diagnostic test that was ordered by the physician or other supplier (or ordered by a party related to the billing physician or other supplier through common ownership or control), subject to an anti-markup payment limitation, if the diagnostic test is performed by a physician who does not "share a practice" with the billing physician or other supplier. (This claim and payment limitation does not apply to clinical diagnostic laboratory tests, which are paid under the Clinical Laboratory Fee Schedule.) Under the anti-markup payment limitation, payment to the billing physician or other supplier (less the deductibles and coinsurance paid by the beneficiary or on behalf of the beneficiary) for the TC or PC of the diagnostic test may not exceed the lowest of the following amounts:

(1) The performing physician/supplier's net charge to the billing physician or other supplier.* (With respect to the TC, the performing supplier is the physician who supervised the test, and with respect to the PC, the performing supplier is the physician who performed the PC.);

(2) The billing physician or other supplier's actual charge; and

(3) The fee schedule amount for the test that would be allowed if the performing physician/supplier billed directly. (See section 10.1.1.2 for information on payment jurisdiction for services subject to the anti-markup payment limitation.)

* The net charge must be determined without regard to any charge that is intended to reflect the cost of equipment or space leased to the performing supplier by or through the billing physician or other supplier.

Exception to the Anti-markup Payment Limitation

If the performing physician is deemed to "share a practice" with the billing physician or other supplier (who ordered the test), the anti-markup payment limitation does not apply. A performing physician is considered to "share a practice" with the billing physician or other supplier if the performing physician furnishes "substantially all" (at least 75 percent) of his or her professional services through the billing physician or other supplier. The "substantially all" services requirement will be satisfied, if, at the time the billing physician or other supplier submits a claim for a service furnished by the performing physician, the billing physician or other supplier has a reasonable belief that: (1) for the 12 months prior to and including the month in which the service was performed, the performing physician furnished substantially all of his or her professional services through the billing physician or other supplier; or (2) the performing physician will furnish substantially all of his or her professional services through the billing physician or other supplier for the next 12 months (including the month in which the service is performed).

If the performing physician does not meet the "substantially all" services test, the performing physician may be deemed to "share a practice" with the billing physician or other supplier if the arrangement complies with a "site of service/same building" test. This alternative approach requires the performing physician to be an owner, employer, or independent contractor of the billing physician or other supplier and requires that the TC or PC be performed "in the office of the billing physician or other supplier." The "office of the billing physician or other supplier" is any medical office space, regardless of the number of locations, in which the ordering physician or other supplier regularly furnishes patient care, and includes space where the billing physician or other supplier furnishes diagnostic testing services, if the space is located in the "same building" (as defined in 42 CFR §411.351 of the physician self-referral rules) in which the ordering physician or other ordering supplier regularly furnishes patient care. With respect to a billing physician or other supplier that is a physician organization (as defined in 42 CFR §411.351 of the physician self-referral rules), the "office of the billing physician or other supplier" is space in which the ordering physician provides substantially the full range of patient care services the ordering physician provides generally. The performance of the TC includes, both, the conducting of the TC as well as the supervision of the TC.

The billing physician or other supplier must keep on file the name, the National Provider Identifier, and address of the performing physician. The physician or other supplier furnishing the TC or PC of the diagnostic test must be enrolled in the Medicare program. No formal reassignment is necessary.

NOTE: When billing for the TC or PC of a diagnostic test (other than a clinical diagnostic laboratory test) that is performed by another physician, the billing entity must indicate the name, address and NPI of the performing physician or supplier in Items 32 and 32a of the Form CMS-1500 claim form.

Effective for claims submitted with a receipt date on and after January 1, 2015, for reference laboratory and anti-markup claims, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier in Item 32a of the CMS-1500 claim form (or its electronic equivalent), even if the performing physician or supplier is enrolled in a different B/MAC jurisdiction. See § 10.1.1.2 for more information regarding claims filing jurisdiction.

If the billing physician or other supplier performs only the TC or the PC and wants to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically (ANSI X12 837) or on separate claims if billing on paper (Form CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

Effective for claims received on or after April 1, 2004:

In order to have appropriate service facility location ZIP code and the acquired price of each test on the claim, when billing for anti-markup tests on the Form CMS-1500 paper claim form each test must be submitted on a separate claim form. Treat paper claims submitted with more than one anti-markup test as unprocessable per §80.3.2.

More than one anti-markup test may be billed on the ANSI X12N 837 electronic format. When more than one test is billed, the total acquired amount must be submitted for each service. Treat claims received with multiple anti-markup tests without line level total acquired amount information as unprocessable per §80.3.2.

Treat paper claims submitted for anti-markup tests with both the technical component (TC) and the professional component (PC) on one claim as unprocessable per §80.3.2 unless the services are submitted with the same date of service and same place of service codes. When a claim is received that includes both services, and the date of service and place of service codes match, assume that the one address in Item 32 applies to both services. Effective for claims with dates of service on or after April 1, 2005, each component of the test must be submitted on a separate claim form. Treat paper claims with dates of service after March 31, 2005 submitted with more than one anti-markup test as unprocessable per §80.3.2.

ANSI X12N 837 electronic claims submitted for anti-markup tests with both the TC and the PC on the same claim must be accepted. Assume that the claim level service facility location information applies to both services if line level information is not provided.

In order to price claims correctly and apply anti-markup payment limitations, global billing is not acceptable for claims received on the Form CMS-1500 or on the ANSI X12N 837 electronic format. Each component must be billed as a separate line item (or on a separate claim per the limitations described above). Treat the claim as unprocessable per §80.3.2 when a global billing is received and there is information on the claim that indicates the test was acquired.

Effective for claims with dates of service on or after January 25, 2005, A/B MACs must accept and process claims for diagnostic tests subject to the anti-markup payment limitation when billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the A/B MAC's jurisdiction, regardless of the location where the service was furnished. Effective April 1, 2005, carriers must price anti-markup test claims based on the ZIP code of the location where the service was rendered

when billed by a laboratory or an IDTF, using a CMS-supplied national abstract file of the MPFS containing the HCPCS codes that are payable under the MPFS as either a TC or PC of a diagnostic test subject to the anti-markup payment limitation for the calendar year. Effective for claims with dates of service on or after October 1, 2007, A/B MACs must use the national abstract file to price all claims for diagnostic tests subject to an anti-markup payment limitation, for all supplier specialty types (including physicians), based on the ZIP code of the location where the service was rendered, in accordance with the A/B MAC jurisdictional pricing rules specified in §10.1.1. (See IOM Publication 100-04, Chapter 23, §30.6, and Addendum for record layouts and instructions for downloading the Abstract File for Diagnostic Tests Subject to the Anti-Markup Payment Limitation.)

NOTE: As with all services payable under the MPFS, the ZIP code is used to determine the appropriate payment locality and corresponding fee for the anti-markup test. When a ZIP code crosses locality lines, CMS uses the dominant locality to determine the corresponding fee.

30.3.7 - Billing for Diagnostic Tests (Other Than Clinical Diagnostic Laboratory Tests) Subject to the Anti-Markup Payment Limitation - Claims Submitted to B/MACs

(***Rev.3047, Issued: 08-22-14, Effective: 01-01-15, Implementation 01-05-15***)

A. General

A physician or other supplier may bill and receive payment for the technical component (TC) or professional component (PC) of a diagnostic test (other than clinical diagnostic laboratory test) that is performed by a physician or other supplier with whom the billing physician or other supplier does not share a practice. Reimbursement for that service is subject to the anti-markup payment limitation. If a physician or other supplier's bill or a request for payment includes a charge for a diagnostic test (other than a clinical diagnostic laboratory test) which the physician or other supplier did not personally perform or supervise, then payment for the test may not exceed the lesser of:

- The performing physician's net charge to the billing physician or other supplier (net any discounts);
- The billing physician's actual charge; or
- The fee schedule amount that would be allowed for the test if the performing physician or other supplier billed directly.

(See §30.2.9 of this chapter for additional information.)

For payment to be made, the physician who acquires the TC or PC of a diagnostic test from an outside source must identify the performing physician or other supplier in Item 32 of the CMS-1500 claim form (or electronic equivalent) by supplying their name, address, and NPI. The billing physician or other supplier must also indicate in Item 20 of the CMS-1500 (or corresponding loop and segment on the ANSI X12N 837) that the test is subject to the anti-markup payment limitation by checking "Yes" and entering the amount the performing physician or other supplier charged. No payment may be made to the physician without this information unless the statement "No anti-markup tests are included" is annotated on the claim.

NOTE: If the billing physician performs only the TC or the PC and wants to bill for both components of the diagnostic test, the TC and PC must be reported as separate line items if billing electronically (ANSI X12 837) or on separate claims if billing on paper (CMS-1500). Global billing is not allowed unless the billing physician or other supplier performs both components.

Effective for claims submitted with a receipt date on and after January 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier in Item 32a of the CMS-1500 claim form (or its electronic equivalent) on anti-markup claims, even if the performing physician or supplier is enrolled in a different B/MAC jurisdiction. (See § 10.1.1.2 for more information regarding claims filing jurisdiction.)

B. Unassigned Claims with Required Documentation

A physician or other supplier may not bill an individual an amount in excess of Medicare's payment, except for any deductible and coinsurance, for the TC or PC of a diagnostic test that is subject to the anti-markup payment limitation. B/MACs must notify physicians and other suppliers that they must indicate when a diagnostic test was acquired, identify the performing physician or other supplier, and show the amount the performing physician or other supplier charged. The notification must inform physician and other suppliers that they are prohibited by §1842(n)(3) of the Act from billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance. Excess amounts collected from the beneficiary must be repaid.

C. Unassigned Claims without Required Documentation

A physician may not bill a beneficiary:

- If the bill does not indicate who performed the test; and

- If the bill indicates that a separate physician or other supplier performed the test, it does not identify the performing physician or other supplier or does not include the amount the performing physician or other supplier charged.

The B/MACs notify the physician when a non-assigned claim for the TC or PC of a diagnostic test subject to the anti-markup payment limitation is received from either the physician or a beneficiary except when the physician submits an assigned claim and the beneficiary submits an unassigned duplicate claim. They use the following sample letter.

> Dear Doctor:
>
> We have received an unassigned claim for diagnostic tests furnished to the patient (Beneficiary Name), on (Date of Service). You are prohibited by §1842(n)(3) of the Social Security Act from billing or collecting any amount unless you indicate that "No anti-markup tests are included" or, if the diagnostic test was acquired, you indicate who performed the test and what the physician or other supplier charged you. Some or all of the required information is missing from your patient's claim. If you have collected any amount from your patient, it must be refunded. This claim may be resubmitted if the required information is included.

D. Beneficiary Information Regarding Unassigned Claims

The B/MACs must notify the beneficiary that the physician is prohibited from:

- Billing the beneficiary when the necessary documentation is not supplied; and

- Billing or collecting an amount in excess of Medicare's payment, except for the deductible and coinsurance, when the required documentation is submitted.

(See chapter 21, for MSN messages.)

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

(***Rev.3047, Issued: 08-22-14, Effective: 01-01-15, Implementation 01-05-15***)

A - Universal Requirements

The following instruction describes "conditional" data element requirements, which are applicable to certain assigned A/B MAC claims. This instruction is minimal and does not include all "conditional" data element requirements, which are universal for processing claims. The CMS has specified which remark code(s)

should be used when a claim fails a particular "return as unprocessable" edit and a remittance advice is used to return the claim. In addition to the specified remark code(s), A/B MACs must include Remark Code MA130 on returned claim(s). Reason code(s) must also be reported on every remittance advice used to return a claim or part of a claim as unprocessable.

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

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

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

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

NOTE: For item 80.3.2.1.2 (a) above, effective for claims with dates of service (DOS) on or after the implementation date of the Phase 2 ordering and referring denial edits, if the Part B clinical lab and imaging technical or global component claim or Durable Medical Equipment, Prosthetics, and Orthotics Suppliers (DMEPOS) claim is denied due to the ordering/referring provider not allowed to order/refer, contractors shall use Group Code CO, Claim Adjustment Reason Code (CARC) 183 and Remittance Advice Remark Codes (RARCs) N574 and MA13 when denying such claims. If the claim is denied due to the ordering/referring provider's name not matching (i.e., the first four letters of the last name provided on the claim don't match what's listed in the provider's record), contractors shall use Group Code CO, CARC 16, RARCs N264 and N575 and MA13.

If the claim is submitted that lists an ordering/referring provider and the required matching NPI is not reported, then the claim shall be rejected using Group Code CO, CARC 16, RARCs N265 and MA13. This is the only instance when a rejection is allowed.

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

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

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

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

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

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

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

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

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

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

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

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

9. *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 ANSI X12N 837 equivalent) belongs to the billing provider OR the performing entity is not a valid, Medicare enrolled entity.*

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

e. For claims received on or after April 1, 2013, if a provider of service or supplier is required to submit a diagnosis in Item 21 of the Form CMS- 1500 (08-05) and an ICD-9-CM "E" code (external causes of injury and poisoning) is reported in the Number 1 field of Item 21. And, effective for dates of service on or after the effective date for ICD-10-CM codes, if an ICD-10-CM diagnosis code within the code range of V00 through Y99 is reported in the Number1 field of Item 21. (Remark Code MA63 is used.)

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

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

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

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

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

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

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

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

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

Effective January 1, 2011 for claims processed on or after January 1, 2011 on the Form CMS-1500, the name, address, and 5 or 9-digit ZIP code, as appropriate, of the location where the service was performed for services paid under the Medicare Physician Fee Schedule and anesthesia services, shall be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1 for services provided in all places of service. (Remark code MA114 is used.)

Effective January 1, 2011, for claims processed on or after January 1, 2011, using the 5010 version of the ANSI X12N 837 P electronic claim form for services payable under the MPFS and anesthesia services when rendered in POS home (or any POS they consider home) if submitted without the service facility location. (Remark code MA114 is used.)

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

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

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services

(***Rev.3047, Issued: 08-22-14, Effective: 01-01-15, Implementation 01-05-15***)

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, until the NPI is required, is not entered in item 33 or if the NPI is not entered in item

33a.of the Form CMS-1500 (8/05) when the NPI is required or, until the NPI is required, if their personal PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required. (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, until the NPI is required, the attending physician's PIN is not entered in item 24K of the Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of the Form CMS-1500 (8/05) when the NPI is required). (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 required) is not present in item 19. (Remark code N324 or N253 is used.)

f. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name is not present in items 17 or 17a., or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N264 or N286 is used.)

g. For all laboratory services, if the services of a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist are used and his or her name is not present in items 17 or in 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (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 MA 114 is used.) Effective for claims received on or after April 1, 2004, the name, address, and ZIP Code of the service location for all services other than those furnished in place of service home – 12 must be entered.

3. When a diagnostic service is billed as *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 in Item 32*, and the NPI* of the performing physician or supplier in Item 32a. If Item 32 and 32a are not entered, remark code MA114 is used.

j. For mammography “diagnostic” and “screening” claims, if a qualified screening center does not accurately enter their 6-digit, FDA-approved certification number in item 32 when billing the technical or global component. (Remark code MA128 is used.)

k. For parenteral and enteral nutrition claims, if the services of an ordering/referring physician, physician assistant, nurse practitioner, clinical nurse specialist are used and their name is not present in item 17 or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (Remark code N264 or N286 is used.)

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

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist’s name, if appropriate, is not entered in item 17, the NPI is not entered in item 17a., or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05). (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 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, physicians 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 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 required) 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 *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 when the NPI is required, if the services were performed at a location other than the place of service home – 12. (Use Remark code MA114)

p. For all physician office laboratory claims, if a 10-digit CLIA laboratory identification number is not present in item 23. This requirement applies to claims for services performed on or after January 1, 1998. (Remark code MA120 is used.)

q. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23, for dates of service through March 31, 2008. (Remark code MA50 is used.) With the use of new modifier Q0, effective for dates of service on and after April 1, 2008, contractors will no longer be able to distinguish an IDE claim from other investigational clinical services. Therefore this edit will no longer apply.

r. For physicians performing care plan oversight services if the 6-digit Medicare provider number of the home health agency (HHA) or hospice is not present in item 23. (Remark code MA49 is used.)

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

t. For claims for artificial hearts covered by Medicare under an approved clinical trial, if procedure code 0051T is entered in Item 24D, and an 8-digit clinical trial number that matches an approved clinical trial listed at: http://www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp#TopOfPage is not entered in Item 19; and the HCPCS modifier Q0 is not entered on the same line as the procedure code in Item 24D, and the diagnosis code V70.7 is not entered in Item 21 and linked to the same procedure code. (As appropriate, use remark code MA97 – Missing/ incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number; M64 – Missing/incomplete/invalid other diagnosis; or claim adjustment reason code 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing.)

u. For clinical trial claims processed **after September 28, 2009**, with dates of service on or after January 1, 2008, claims submitted with either the modifier QV or the modifier Q1, if the diagnosis code V70.7 is not submitted with the claim.

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

Medicare Claims Processing Manual
Chapter 16 - Laboratory Services

40.1.1.1 - Paper Claim Submission To Carriers/B MAC
(Rev.3047, Issued: 08-22-14, Effective: 01-01-15, Implementation 01-05-15)

An independent clinical laboratory that elects to file a paper claim form shall file Form CMS-1500 for a referred laboratory service (as it would any laboratory service). The line item services must be submitted with a modifier 90.

An independent clinical laboratory that submits claims in paper format) may not combine non-referred (i.e., self-performed) and referred services on the same CMS 1500 claim form. When the referring laboratory bills for both non-referred and referred tests, it shall submit two separate claims, one claim for non-referred tests, the other for referred tests. If billing for services that have been referred to more than one laboratory, the referring laboratory shall submit a separate claim for each laboratory to which services were referred (unless one or more of the reference laboratories are separately billing Medicare). A paper claim that contains both non-referred and referred tests is returned as unprocessable. When the referring laboratory is the billing laboratory, the reference laboratory's name, address, and ZIP Code shall be reported in item 32 on the CMS-1500 claim form to show where the service (test) was actually performed. The NPI shall be reported in item 32a. Also, the CLIA number of the reference laboratory shall be reported in item 23 on the CMS-1500 claim form. A paper claim that does not have the name, address, and ZIP Code of the reference laboratory in item 32 and NPI in 32a or the CLIA number of the reference laboratory in item 23 is returned as unprocessable.

EXAMPLE: A physician has ordered the ABC Laboratory to perform carcinoembryonic antigen (CEA) and hemoglobin testing for a patient. Since the ABC Laboratory is approved to perform tests only within the hematology LC level (which includes the hemoglobin test), it refers the CEA testing (which is a routine chemistry LC) to the XYZ laboratory.

Result: The ABC laboratory submits a claim for the hemoglobin test and reports its CLIA number in item 23 on the CMS-1500 form. Since the ABC laboratory referred the CEA test to the XYZ laboratory to perform, the ABC laboratory (billing laboratory) submits a second claim for the CEA testing, reporting XYZ's CLIA number in item 23 on the CMS-1500 form. The XYZ laboratory's name, address, and ZIP Code are also reported in item 32 and the NPI is reported in item 32a on Form CMS-1500 to show where the service (test) was actually rendered.

NOTE: *Effective for claims submitted with a receipt date on and after January 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier in Item 32a on anti-markup and reference laboratory claims, even if the performing physician or supplier is enrolled in a different B/MAC jurisdiction. See Pub. 100-04, Chapter 1, § 10.1.1 for more information regarding claims filing jurisdiction.*

40.1.1.2 - Electronic Claim Submission to Carriers/B MAC
(*Rev.3047, Issued: 08-22-14, Effective: 01-01-15, Implementation 01-05-15*)

Electronic Claim Submission

American National Standards Institute (ANSI) X12N 837 (HIPAA version) format electronic claims:

CLIA number:

An ANSI claim for laboratory testing will require the presence of the performing (and billing) laboratory's CLIA number; if tests are referred to another laboratory, the CLIA number of the laboratory where the testing is rendered must also be on the claim. An ANSI electronic claim for laboratory testing must be submitted using the following format:

ANSI Electronic claim: the billing laboratory performs all laboratory testing.

The independent laboratory submits a single claim for CLIA-covered laboratory tests and reports the billing laboratory's number in:

X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

ANSI Electronic claim: billing laboratory performs some laboratory testing; some testing is referred to another laboratory.

The ANSI electronic claim will not be split; CLIA numbers from both the billing and reference laboratories must be submitted on the same claim. The presence of the '90' modifier at the line item service identifies the referral tests. Referral laboratory claims are only permitted for independently billing clinical laboratories, specialty code 69.

The billing laboratory submits, on the same claim, tests referred to another (referral/rendered) laboratory, with modifier 90 reported on the line item and reports the referral laboratory's CLIA number in:

X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4

EXAMPLE: A physician has ordered the DEF independent laboratory to perform glucose testing and tissue typing for a patient. Since the DEF Laboratory is approved to perform only at the routine chemistry LC level (which includes glucose testing), it refers the tissue-typing test to the GHI laboratory.

The DEF laboratory submits a single claim for the glucose and tissue typing tests; the line item service for the glucose test is submitted without a '90' modifier since the DEF laboratory performed this test. The CLIA number for the DEF laboratory is entered in the electronic claim in:

X12N 837 (HIPAA version) loop 2300, REF02. REF01 = X4

On the same claim, the line item service for the tissue typing test is submitted with a '90' modifier and the referral/rendering GHI laboratory's CLIA number is entered on the electronic claim in:

X12N 837 (HIPAA version) loop 2400, REF02. REF01 = F4

Reference Laboratory's Address:

An electronic claim for laboratory testing requires the presence of the performing and billing laboratory's, name and address. The performing laboratory for a service with a line item CPT 90 modifier requires provider information for the appropriate 837 loop.

NOTE: *Effective for claims submitted with a receipt date on and after January 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier on the claim on reference laboratory claims, even if the performing physician or supplier is enrolled in a different B/MAC jurisdiction. See Pub. 100-04, Chapter 1, § 10.1.1 for more information regarding claims filing jurisdiction.*

Medicare Claims Processing Manual
Chapter 26 - Completing and Processing Form CMS-1500 Data Set

Item 19 - Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) date patient was last seen and the NPI of his/her attending physician when a physician providing routine foot care submits claims.

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Enter either a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) x-ray date for chiropractor services (if an x-ray, rather than a physical examination was the method used to demonstrate the subluxation). By entering an x-ray date and the initiation date for course of chiropractic treatment in item 14, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, is on file, along with the appropriate x-ray and all are available for carrier review.

Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.

Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.

Enter the statement "Homebound" when an independent laboratory renders an EKG tracing or obtains a specimen from a homebound or institutionalized patient. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, "Covered Medical and Other Health Services," and Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, "Laboratory Services From Independent Labs, Physicians and Providers," and Pub. 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," respectively for the definition of "homebound" and a more complete definition of a medically necessary laboratory service to a homebound or an institutional patient.)

Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a non-participating physician/supplier who accepts assignment on a claim. In this case, payment can only be made directly to the beneficiary.

Enter the statement, "Testing for hearing aid" when billing services involving the testing of a hearing aid(s) is used to obtain intentional denials when other payers are involved.

When dental examinations are billed, enter the specific surgery for which the exam is being performed.

Enter the specific name and dosage amount when low osmolar contrast material is billed, but only if HCPCS codes do not cover them.

Enter a 6-digit (MM | DD | YY) or an 8-digit (MM | DD | CCYY) assumed and/or relinquished date for a global surgery claim when providers share post-operative care.

Enter demonstration ID number "30" for all national emphysema treatment trial claims.

Enter demonstration ID number “56” for all national Laboratory Affordable Care Act Section 113 Demonstration Claims.

Enter the NPI of the physician who is performing the technical or professional component of a diagnostic test that is subject to the anti-markup payment limitation. (See Pub. 100-04, chapter 1, section 30.2.9 for additional information.)

NOTE: Effective May 23, 2008, all identifiers submitted on the Form CMS-1500 MUST be in the form of an NPI.

Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, chapter 8, section 60.7.2.)

Individuals and entities who bill carriers or A/B MACs for administrations of ESAs or Part B anti-anemia drugs not self-administered (other than ESAs) in the treatment of cancer must enter the most current hemoglobin or hematocrit test results. The test results shall be entered as follows: TR= test results (backslash), R1=hemoglobin, or R2=hematocrit (backslash), and the most current numeric test result figure up to 3 numerics and a decimal point [xx.x]). Example for hemoglobin tests: TR/R1/9.0, Example for Hematocrit tests: TR/R2/27.0.

Item 31 - Enter the signature of provider of service or supplier, or his/her representative, and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alpha-numeric date (e.g., January 1, 1998) the form was signed.

In the case of a service that is provided incident to the service of a physician or non-physician practitioner, when the ordering physician or non-physician practitioner is directly supervising the service as in 42 CFR 410.32, the signature of the ordering physician or non-physician practitioner shall be entered in item 31. When the ordering physician or non-physician practitioner is not supervising the service, then enter the signature of the physician or non-physician practitioner providing the direct supervision in item 31.

NOTE: This is a required field, however the claim can be processed if the following is true. If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim or if the signature field has "Signature on File" and/or a computer generated signature.

Item 32 – For services payable under the physician fee schedule and anesthesia services, **e**nter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Effective for claims received on or after April 1, 2004, enter the name, address, and ZIP code of the service location for all services other than those furnished in place of service home – 12. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, only one name, address and ZIP code may be entered in the block. If additional entries are needed, separate claim forms shall be submitted. Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for all POS codes.

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for anti-markup tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. (See Pub. 100-04, chapter 1, §10.1.1.2 for more information on payment jurisdiction for claims subject to the anti-markup limitation.)

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States. These claims will not include a valid ZIP code. When a claim is received for these services on a beneficiary submitted Form CMS-1490S, before the claim is entered in the system, it should be determined if it is a foreign claim. If it is a foreign claim, follow instructions in chapter 1 for disposition of the claim. The

carrier processing the foreign claim will have to make necessary accommodations to verify that the claim is not returned as unprocessable due to the lack of a ZIP code.

For durable medical, orthotic, and prosthetic claims, the name and address of the location where the order was accepted must be entered (DME MAC only). This field is required. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier. This item is completed whether the supplier's personnel performs the work at the physician's office or at another location.

If the supplier is a certified mammography screening center, enter the 6-digit FDA approved certification number.

Complete this item for all laboratory work performed outside a physician's office. If an independent laboratory is billing, enter the place where the test was performed.

Item 32a - If required by Medicare claims processing policy, enter the NPI of the service facility.

Effective for claims submitted with a receipt date on and after January 1, 2015, the billing physician or supplier must report the NPI of the performing physician or supplier in Item 32a on all anti-markup and reference laboratory claims, even if the performing physician or supplier is enrolled in a different jurisdiction.

Item 32b - Effective May 23, 2008, Item 32b is not to be reported.

Item 33 - Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.

Item 33a - Enter the NPI of the billing provider or group. This is a required field.

Item 33b - Effective May 23, 2008, Item 33b is not to be reported.

Medicare Claims Processing Manual

Chapter 35 – Independent Diagnostic Testing Facility (IDTF)

30 - Diagnostic Tests Subject to the Anti-Markup Payment Limitation

(Rev.3047, Issued: 08-22-14, Effective: 01-01-15, Implementation 01-05-15)

In most instances, physicians working for an IDTF do not order diagnostic tests because such tests are generally ordered by the patient's treating physician. If a physician working for an IDTF does not order a diagnostic test, the test is not subject to the anti-markup payment limitation. However, if a physician working for an IDTF (or a physician financially related to the IDTF through common ownership or control) orders a diagnostic test payable under the Medicare Physician Fee Schedule (MPFS), the anti-markup payment limitation may apply (depending on whether the performing physician or other supplier meets the "sharing a practice" requirements). For additional information, see Pub. 100-04, chapter 1, §30.2.9.

If a physician working for an IDTF (or a physician financially related to the IDTF through common ownership or control) orders and the IDTF bills for a diagnostic test that is performed by another physician or supplier, the performing physician or other supplier must be enrolled in the Medicare program. No formal reassignment is necessary; however, reassigned diagnostic testing services may also be subject to the anti-markup payment limitation.

The billing entity must report on the CMS 1500 claim form (or corresponding loop and segment of the ANSI X12N 837) the name, NPI, and address of the performing physician or other supplier. The acquisition price of either the TC or PC of the diagnostic test must also be reported on the claim.

Effective for claims with dates of service on or after January 25, 2005, carriers must accept and process claims for diagnostic tests subject to the anti-markup payment limitation billed by suppliers (including laboratories, physicians, and independent diagnostic testing facilities [IDTFs]) enrolled in the carrier's jurisdiction, for services furnished anywhere in the United States.

Effective for claims submitted with a receipt date on and after January 1, 2015, the billing physician or supplier must report the name, address, and NPI of the performing physician or supplier in Item 32a on anti-markup and reference laboratory claims, even if the performing physician or supplier is enrolled in a different B/MAC jurisdiction. See Pub. 100-04, Chapter 1, § 10.1.1 for more information regarding claims filing jurisdiction.

Effective April 1, 2005, carriers must price claims for diagnostic tests that are subject to the anti-markup payment limitation based on the ZIP Code of the location where the service was rendered, using a CMS-supplied abstract file containing the HCPCS codes that are payable under the MPFS as an anti-markup test for the calendar year. (See Pub. 100-04, chapter 23, §30.6 and Addendum for record layouts and instructions for downloading the Abstract File for Purchased Diagnostic Tests/Interpretations.) Carriers must pay the lesser of: (a) the net acquisition price, (b) the billing entity's actual charge, or (c) the fee schedule amount as if the test was billed by the performing supplier.

NOTE: As with all services payable under the MPFS, the ZIP Code is used to determine the appropriate payment locality and corresponding fee that is used to price the service that is subject to the anti-markup payment limitation. When a ZIP Code crosses county lines, CMS uses the dominant locality to determine the corresponding fee.

SAMPLE PECOS FILE LAYOUT FOR CR 8806

Description	Field Name	Length	Default Value	Start Position	PECOS Table (Enrollment)	PECOS Field	PECOS Table (Affidavit)	PECOS Field
NPI	NPI	10	N/A	1	PEC_NPI	NPI	PEC_NPI	NPI
First Name	FNAME	25	N/A	11	PEC_IND_NAME	FIRST_NAME	PEC_INDVDL_NAME	FIRST_NAME
Middle Name	MNAME	25	N/A	36	PEC_IND_NAME	MDL_NAME	PEC_INDVDL_NAME	MDL_NAME
Last Name	LNAME	35	N/A	61	PEC_IND_NAME	LAST_NAME	PEC_INDVDL_NAME	LAST_NAME
Legal Business Name	BASE-LBA-NAME	70	N/A	96	PEC_ORG_BUSNS_NAME	ORG_NAME	PEC_ORG_BUSNS_NAME	ORG_NAME
DBA Name	BASE-DBA-NAME	70	N/A	166	PEC_ORG_DBA_NAME	ORG_NAME	PEC_ORG_DBA_NAME	ORG_NAME
Specialty Code	SPCLTY_CD	2	N/A	236	PEC_ENRT_NPHY_SPC, PEC_ENRT_PHY_SPC	PHYSN_SPCLTY_CD	PEC_AFDVT_NPHYSN_SPCLTY, PEC_AFDVT_PHYSN_SPCLTY	NPHYSN_SPCLTY_CD, PHYSN_SPCLTY_CD
Specialty Description	SPCLTY_DESC	150	N/A	238	PEC_NPHY_SPC_REF, PEC_PHY_SPC_REF	PHYSN_SPCLTY_DESC	PEC_NPHY_SPC_REF, PEC_PHY_SPC_REF	PHYSN_SPCLTY_DESC
PIN Effective Date	EFF_DT	8	N/A	388	PEC_MDCR_NUM	EFCTV_DT	PEC_AFDVT_MDCR/ PEC_AFDVT_ORDR_RFRG	EFCTV_DT
PIN Termination Date	TRM_DT	8	N/A	396	PEC_MDCR_NUM	END_DT	PEC_AFDVT_MDCR/ PEC_AFDVT_ORDR_RFRG/ PEC_AFDVT	END_DT
Filler	FILLER	37	N/A	404	N/A	N/A	N/A	N/A
Total Length		**441**						