

# Claim Submission Errors

April 2009

Tennessee, Idaho, and North Carolina Part B Manual  
provided by CIGNA Government Services.

## Return Unprocessable Claims

This editing process returns paper and electronic claims to the provider as unprocessable if the claim contains incomplete or invalid information. No appeal rights are afforded to these claims, or portion of these claims, because no "initial determination" can be made.

### What Does "Return as Unprocessable" Mean?

Returning a claim as unprocessable does not mean your Medicare carrier will physically return every claim you submit with incomplete or invalid information. The term "return as unprocessable" is used to refer to the many processes utilized by your Medicare carrier for notifying you that your claim cannot be processed, and it must be corrected and resubmitted. In some cases, the paper claim is returned to you from the carrier mailroom. In most cases, the claim is "returned" as unprocessable on the Medicare Remittance Notice or Electronic Remittance Notice.

### How Should These Errors Be Corrected?

Unprocessable claims have no "appeal rights" with them since the claim contained invalid or incomplete information. This means that these claims cannot be corrected through Redeterminations, the first level of appeals. Unprocessable claims also do not qualify for correction through the reopening or adjustment process. These claims should be resubmitted electronically as new claims once the error has been corrected.

## Medicare Remittance Advice

CIGNA Government Services frequently receives calls asking why claims are reduced, denied or returned as unprocessable. In the Center for Medicare & Medicaid Services (CMS) continuing effort to eliminate any variations in the administration of Medicare, the provider remittance was standardized to provide a uniform level of information to all providers of health care about the decisions made on their claims.

The MRN can be broken down into four parts:

1. Mailing address and provider identification.
2. Claim level information.
3. Total remittance information.
4. Reason, Remark, and Medicare Outpatient Adjudication (MOA) code definitions.

Of course, the most important information found on the MRN is the claim level information and the Reason, Remark, and MOA code definitions. These areas give the provider and billing staff all the information necessary to finalize payment information for a particular claim or service.

### Section One - Mailing Address and Provider Identification

Section One contains the mailing address and provider identification. This section also contains a Medicare bulletin for providers.

The mailing address and provider identification are very important to the MRN. This area verifies the provider of service and his/her billing address, the number of pages, the date of the MRN, the check number, and it contains a provider bulletin with an important and timely message.



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|                           |              |            |
|---------------------------|--------------|------------|
| CIGNA GOVERNMENT SERVICES |              | MEDICARE   |
| P. O. BOX 1465            |              | REMITTANCE |
| NASHVILLE, TN 372020000   |              | NOTICE     |
| THE DOCTOR                | NPI #:       | 111111116  |
| 123 THREE STREET          | PAGE #:      | 1          |
| SOMEWHERE, TN 372002531   | DATE:        | 01/24/2009 |
|                           | CHECK/EFT #: | 111111117  |

Alert: This area is reserved to communicate current alerts.

## Section Two - Claim level information

Section Two contains claim information, including Reason codes, MOA codes, Remark codes, and Patient Responsibility.

The first line of the claim level information contains the name of the patient, the patient's Medicare number, the account number, the internal control number (ICN), the assignment verification, and claim level MOA codes.

The second line contains information about the performing provider's National Provider Identification Number (NPI), the date of service, the place of service, the number of services billed, the procedure codes billed, the modifiers billed, the billed amount, the allowed amount, the deductible applied, the applicable coinsurance amount, the contractual obligation amount, the provider paid amount, and the Reason Codes and amounts.

Any line-level remarks will be identified immediately beneath the applicable line.

Finally, the claim information contains the patient's total responsibility and the claim totals for the billed amount, the allowed amount, the deductible applied, the applicable coinsurance amount, and the provider paid amount.

In the case of Medicare Secondary Payer (MSP) claims, interest payments, or other adjustments, there will be another line added detailing this information. The net payment reports the payment after all adjusted payments have been applied.

| REND           | PROV      | SERV DATE   | POS | NOS        | PROC         | MODS | BILLED | ALLOWED            | DEDUCT | COINS         | GRP/RC-AMT | PROV PD  |
|----------------|-----------|-------------|-----|------------|--------------|------|--------|--------------------|--------|---------------|------------|----------|
| NAME           | JOE, MOE  |             | HIC | 123654789C |              | ACNT | 7000   |                    | ICN    | 0000000000001 | ASG Y      | MOA MA01 |
|                | 111111116 | 0101 010109 | 11  | 1          | 99213        |      | 50.00  | 50.00              | 0.00   | 11.00         |            | 40.00    |
| PT RESP        |           | 11.00       |     |            | CLAIM TOTALS |      | 50.00  | 50.00              | 0.00   | 11.00         |            | 40.00    |
| ADJ TO TOTALS: | PREV PD   |             |     |            | INTEREST     |      | 0.00   | LATE FILING CHARGE |        | 0.00          | NET        | 0.00     |

## Section Three - Total Remittance Information

Section Three is the MRN detail information. This area includes information totals on the MRN, including the total claims, the total billed amount, the total allowed amount, the total deductible applied, the total coinsurance amount, the total reason codes amount, the total provider paid amount, the total of other adjustments, and the amount of the check.

|         |             |            |             |            |          |              |             |              |           |
|---------|-------------|------------|-------------|------------|----------|--------------|-------------|--------------|-----------|
| TOTALS: | # OF CLAIMS | BILLED AMT | ALLOWED AMT | DEDUCT AMT | COIN AMT | TOTAL RC-AMT | PROV PD AMT | PROV ADJ AMT | CHECK AMT |
|         | 1           | 95.00      | 58.87       | 35.05      | 4.16     | 36.13        | 19.66       | 0.00         | 19.66     |

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## Section Four - Reason, Remark, & Medicare Outpatient Adjudication (MOA) Code Definitions

Section Four contains the description for Group codes, Reason codes, Remarks codes, and MOA codes.

Group codes identify financial responsibility and are used in conjunction with Reason codes and the amount of responsibility for the claim.

Remarks codes are specific remarks for a line item, usually concerning a denial or rejection. These codes are found beneath the applicable line item that is in the claim level information section.

MOA codes contain information for the entire claim and are found on the first line of the claim information section.

### GLOSSARY: Group, Reason, MOA, Remark and Adjustment Code

|    |   |
|----|---|
| BF | Balance Forward   |
| CO | Contractual Obligation. The amount for which the provider is financially liable. The patient may not be billed for this amount. |
| CR | Correction/Reversal of a previously adjudicated service/claim.  |
| IN | Interest.   |
| OA | Other Adjustment.   |
| PR | Patient Responsibility. The amount that may be billed to a patient or another payer.  |

#### Reason Codes:

CO-42 Charges exceed our fee schedule or maximum allowable amount.

#### Remark Codes:

#### MOA Codes:

MA01 If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late.

## SUMMARY - Important Areas of the MRN

The most important information found on the MRN is the claim level information and the Reason, Remark, and MOA code definitions.

|   |   |  |
|---|---|--|
| CIGNA GOVERNMENT SERVICES<br>PO BOX 1465<br>NASHVILLE, TN 37202 |   | MEDICARE<br>REMITTANCE<br>NOTICE         |
| THE DOCTOR<br>123 THREE STREET<br>SOMEWHERE, TN 372002531       | PROVIDER #:<br>PAGE #:<br>DATE:<br>CHECK/EFT #: | 111111116<br>1<br>01/24/2009<br>11111117 |

Alert: This area is reserved to communicate current alerts.

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| REND           | PROV        | SERV DATE | POS | NOS          | PROC | MODS | BILLED | ALLOWED            | DEDUCT | COINS         | GRP/RC-AMT | PROV PD  |
|----------------|-------------|-----------|-----|--------------|------|------|--------|--------------------|--------|---------------|------------|----------|
| NAME           | JOE, MOE    |           | HIC | 123654789C   |      | ACNT | 7000   |                    | ICN    | 0000000000001 | ASG Y      | MOA MA01 |
| 1111111116     | 0101 010109 | 11        | 1   | 99213        |      |      | 50.00  | 50.00              | 0.00   | 11.00         |            | 40.00    |
| PT RESP        | 11.00       |           |     | CLAIM TOTALS |      |      | 50.00  | 50.00              | 0.00   | 11.00         |            | 40.00    |
| ADJ TO TOTALS: | PREV PD     |           |     | INTEREST     |      | 0.00 |        | LATE FILING CHARGE |        | 0.00          | NET        | 0.00     |

| REND           | PROV        | SERV DATE | POS | NOS          | PROC | MODS | BILLED | ALLOWED            | DEDUCT | COINS         | GRP/RC-AMT | PROV PD  |
|----------------|-------------|-----------|-----|--------------|------|------|--------|--------------------|--------|---------------|------------|----------|
| NAME           | JOE, MOE    |           | HIC | 123654789C   |      | ACNT | 7000   |                    | ICN    | 0000000000001 | ASG Y      | MOA MA07 |
| 1111111116     | 0101 010109 | 11        | 1   | 99213        |      |      | 50.00  | 50.00              | 0.00   | 11.00         | CO16       | 40.00    |
| PT RESP        | 11.00       |           |     | CLAIM TOTALS |      |      | 50.00  | 50.00              | 0.00   | 11.00         |            | 40.00    |
| ADJ TO TOTALS: | PREV PD     |           |     | INTEREST     |      | 0.00 |        | LATE FILING CHARGE |        | 0.00          | NET        | 0.00     |

| TOTALS: | # OF CLAIMS | BILLED AMT | ALLOWED AMT | DEDUCT AMT | COIN AMT | TOTAL RC-AMT | PROV PD AMT | PROV ADJ AMT | CHECK AMT |
|---------|-------------|------------|-------------|------------|----------|--------------|-------------|--------------|-----------|
|         | 1           | 50.00      | 50.00       | 0.00       | 11.00    | 10.00        | 40.00       | 0.00         | 40.00     |

| GLOSSARY: Group, Reason, MOA, Remark and Adjustment Codes: |   |
|--|---|
| CO   | Contractual obligation. The patient may not be billed for this amount.  |
| OA   | Other adjustment.   |
| PR   | Patient responsibility.   |
| 16   | Claim/Service lacks information which is needed for adjudication.   |
| 42   | Charges exceed our fee schedule or maximum allowable amount.  |
| M77  | Incomplete/invalid place of service(s).   |
| MA01   | If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 6 months of the date of this notice, unless you have a good reason for being late. |
| MA07   | The claim information has also been forwarded to Medicaid for review.   |
| MA13   | You may be subject to penalties if you bill the beneficiary for amounts not reported with the PR(Patient responsibility) group code.  |
| MA130  | Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit the correct information to the appropriate fiscal intermediary or carrier.   |

## Claim Submission Errors

Most of the following claim submission errors will have a Group/Reason Code CO-16 (Claim/Service lacks information needed for adjudication). When you receive a Group/Reason Code CO-16, it will be accompanied by either a Remarks Code or MOA Code identifying the missing/invalid information needed to process the claim.

For complete CMS-1500 claim form instructions, refer to the CMS Manual System, Pub. 100-4, Medicare Claims Processing Manual, Chapter 26.

<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

**IMPORTANT:** The instructions in this manual refer to the new CMS-1500 claim form (Version 08-05). Use of the new claim form is available beginning 1/2/07. Use of the new claim form was to have been mandatory 4/1/07. Because CMS has learned that incorrectly formatted versions of the revised form were being sold by print vendors, specifically the Government Printing Office

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(GPO), they have decided to extend the acceptance period of the Form CMS-1500 (12-90) version beyond the original April 1, 2007 deadline while this situation is resolved. For complete information, see [http://www.cms.hhs.gov/ElectronicBillingEDITrans/16\\_1500.asp](http://www.cms.hhs.gov/ElectronicBillingEDITrans/16_1500.asp).

Web-based training for completion of the CMS-1500 claim form using the earlier version of the claim form (Version 12-90) is available on the Internet at: [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=1](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1). The 12-90 version of the claim form will be accepted for processing until CMS advises contractors to stop accepting it. They are targeting June 1, 2007, as the date for requiring paper claim submitters to use the CMS-1500 (08-05) version.

## Incorrect Beneficiary Number

|                      |  |
|----------------------|--|
| <b>CO-16</b>         | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>MOA CODE MA27</b> | Missing/incomplete/invalid entitlement number or name shown on the claim.  |

Providers are encouraged to keep a copy of each patient's Medicare card and other insurance cards on file. The Medicare card shows the beneficiary's Medicare coverage [Hospital (Part A), Medical (Part B)] and the effective dates.

Be sure to report the patient's name and Medicare Health Insurance Claim Number (HICN) exactly as they appear on the Medicare card. Do not place hyphens or blanks in the HICN field.

If the Medicare card shows that the beneficiary name has a suffix (e.g., Jr., Sr., II, III, etc.), report the name exactly as shown on the card. If claims are filed electronically, providers should ensure the EMC file loop 2010BB, NM107 (the suffix field) is populated and that the suffix is not added to the beneficiary's last name.

## Missing/Incomplete/Invalid Group Practice Information.

|                       |  |
|-----------------------|--|
| <b>CO-16</b>          | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>MOA CODE MA112</b> | Missing/incomplete/invalid group practice information.   |

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

**Item 33a Form CMS-1500 (08-05)** - Effective May 23, 2007, and later, you MUST enter the National Provider Identifier (NPI) of the billing provider or group. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007. This is a required field.

**Item 33b Form CMS-1500 (08-05)** - Enter the ID qualifier 1C followed by one blank space and then the Provider Identification Number (PIN) of the billing provider or group. Effective May 23, 2007, and later, 33b is not to be reported.

For a provider who is not a member of a group practice (e.g., private practice), enter the NPI/PIN of the individual physician/practitioner.

If a group practice is billing, then the group NPI/PIN is reported.

In addition, enter the information for the performing provider of service who is a member of the group practice reported in Item 33 as follows:

**Item 24I Form CMS-1500 (08-05)** - Enter the ID qualifier 1C in the shaded portion. Effective May 23, 2007, and later, 1C is not to be reported.

**Item 24J Form CMS-1500 (08-05)** - Prior to May 23, 2007, enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the PIN of the supervisor in the shaded portion.

Effective May 23, 2007 and later, do not use the shaded portion. Beginning January 1, 2007, enter the rendering provider's NPI number in the lower portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.

## Medicare Secondary Payer Information

|                      |  |
|----------------------|--|
| <b>CO-16</b>         | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>REM CODE N245</b> | Incomplete/invalid plan information for other insurance.   |

## Insurance Primary to Medicare

Circumstances under which Medicare payment may be secondary to other insurance include:

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- Group Health Plan Coverage
  - Working Aged;
  - Disability (Large Group Health Plan); and
  - End Stage Renal Disease;
- No Fault and/or Other Liability; and
- Work-Related Illness/Injury:
  - Workers' Compensation;
  - Black Lung; and
  - Veterans Benefits.

- lab has no MSP information for the beneficiary, the lab will enter the word "None" in Block 11 of Form CMS-1500, when submitting a claim for payment of a reference lab service. Where there has been no face-to-face encounter with the beneficiary, the claim will then follow the normal claims process. When a lab has a face-to-face encounter with a beneficiary, the lab is expected to collect the MSP information and bill accordingly.

For complete information on these MSP provisions, see CMS Online Manual, Pub. 100-05, Medicare Secondary Payer Manual at: <http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

**NOTE:** For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.

**Item 4-** If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

**Item 6 -** Check the appropriate box for patient's relationship to insured when item 4 is completed.

**Item 7 -** Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed.

**Item 11 - THIS ITEM MUST BE COMPLETED, IT IS A REQUIRED FIELD. BY COMPLETING THIS ITEM, THE PHYSICIAN/SUPPLIER ACKNOWLEDGES HAVING MADE A GOOD FAITH EFFORT TO DETERMINE WHETHER MEDICARE IS THE PRIMARY OR SECONDARY PAYER.**

- If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed.
 

**NOTE:** Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11.
- If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12.
- If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.
- If a lab has collected previously and retained MSP information for a beneficiary, the lab
- may use that information for billing purposes of the non-face-to-face lab service. If the

**NOTE:** The Administrative Simplification Compliance Act (ASCA) requires mandatory electronic submission of claims unless a provider qualifies for one of the exceptions. The most common exception is that a small provider (fewer than 10 employees) may, if they choose, submit paper claims. ASCA provisions for mandatory submission of electronic claims applies to Medicare Secondary Payer claims unless there are multiple payers primary to Medicare (for example, both Workers' Compensation and Employer Group Health insurance should be filed before filing a claim with Medicare for any additional payment.) For additional information on submitting MSP claim information electronically see the CIGNA Government Service Online Education Course "Billing MSP Claims Electronically" at: [http://www.cignagovernmentservices.com/medicare\\_dynamic/Education/index.asp](http://www.cignagovernmentservices.com/medicare_dynamic/Education/index.asp).

**NOTE:** For a paper claim to be considered for Medicare secondary payer benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.

## Ordering/Referring Provider Information

|                      |  |
|----------------------|--|
| <b>CO-16</b>         | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>REM CODE N286</b> | Missing/incomplete/invalid referring provider primary identifier   |

All claims for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name (Item 17). See Items 17a and 17b below for further guidance on reporting the referring/ordering provider's UPIN and/or NPI.

Referring physician - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

Ordering physician - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. See Pub 100-02, Medicare Benefit Policy Manual, chapter

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15 (<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>) for non-physician practitioner rules. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The following services/situations require the submission of the referring/ordering provider information:

- Medicare covered services and items that are the result of a physician's order or referral;
- Parenteral and enteral nutrition;
- Immunosuppressive drug claims;
- Hepatitis B claims;
- Diagnostic laboratory services;
- Diagnostic radiology services;
- Portable x-ray services;
- Consultative services;
- Durable medical equipment;
- When the ordering physician is also the performing physician (as often is the case with in-office clinical laboratory tests);
- When a service is incident to the service of a physician or non-physician practitioner, the name of the physician or non-physician practitioner who performs the initial service and orders the non-physician service must appear in item 17;
- When a physician extender or other limited licensed practitioner refers a patient for consultative service, submit the name of the physician who is supervising the limited licensed practitioner.

**Item 17** - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

All physicians who order or refer Medicare beneficiaries or services must report either a National Provider Identifier (NPI) or Unique Physician Identification Number (UPIN) or both prior to May 23, 2007. After that date, an NPI (but not a UPIN) must be reported even though they may never bill Medicare directly.

**NOTE:** Field 17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

**Item 17a** – Enter the CMS-assigned Unique Physician Identification Number (UPIN) of the referring/ordering physician listed in item 17. The UPIN may be reported on the Form CMS-1500 until May 22, 2007, and MUST be reported if an NPI is not available.

**Item 17b Form CMS-1500 (08-05)** – Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available. The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007.

**NOTE:** Field 17a and/or 17b is required when a service was ordered or referred by a physician. Effective May 23, 2007, and later, 17a is not to be reported but 17b MUST be reported when a service was ordered or referred by a physician.

When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

## Missing or Inconsistent Modifier

|             |   |
|-------------|---|
| <b>CO-4</b> | The procedure code is inconsistent with the modifier used, or a required modifier is missing. |
|-------------|---|

Modifiers are two-character codes that are appended to procedure codes to further describe the procedure or service in Item 24d of the CMS-1500 claim form (or the equivalent electronic field). Modifiers may be alpha-alpha (JJ), numeric-numeric (25), or alpha-numeric (T2). Some modifiers describe additional work or circumstances that could impact reimbursement. Other modifiers simply provide additional information and do not impact reimbursement. CPT (Level 1) modifiers are published in the CPT manual.

HCPCS Level II (CMS-assigned) are published in the HCPCS book or are available online at: <http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp#TopOfPage>

The electronic claim format and the new CMS-1500 (08-05) claim form accommodate four (4) modifiers per service line in the claim submission.

CIGNA Government Services would like to remind all providers that it is imperative when submitting claims containing pricing modifiers, that the pricing modifier should be suffixed as the first modifier listed with each applicable procedure code. This will help to ensure appropriate pricing and payment of the claim. Please access the following link for additional information: <http://www.cignagovernmentservices.com/partb/pubs/news/2005/0605/Cope2621.html>.

Use the Physician Fee Schedule (PFS) Relative Value file available at <http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/list.asp?listpage=3> to help determine what procedure codes may appropriately have modifiers for bilateral surgery; multiple surgery; assistant at surgery; technical and professional components; cosurgery, etc. Open the zip file "RVU07A4" and

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view or download the Excel file PPRRVU07 and the Word file RVUUF07.

## Place of Service

|                     |  |
|---------------------|--|
| <b>CO-16</b>        | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>REM CODE M77</b> | Missing/incomplete/invalid place of service.   |

Two-digit place of service (POS) codes are required in Item 24b of the CMS-1500 claim form (or the electronic equivalent) for each line of your claim submission. We encourage providers to verify that they are reporting the POS code that applies to the setting in which the service was provided **and** that the submitted procedure code is compatible with that POS.

For example, Office or Other Outpatient Consultation (procedure codes 99241-99245) should be billed with POS codes 11 (Office), 22 (Outpatient Hospital), 23 (Emergency Room), etc., while an Inpatient Consultation (99251-99255) should be billed with POS 21 (Inpatient Hospital), 31 (Skilled Nursing Facility), etc.

Evaluation and Management and Psychiatric Therapeutic codes are also edited for compatibility with the POS code submitted.

For a complete listing of place of service codes and definitions, refer to the CMS Online Manual, Pub.100-04, Medicare Claims Processing, Chapter 26, Section 10 (<http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>).

## Diagnosis Codes

|                     |  |
|---------------------|--|
| <b>CO-16</b>        | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>REM CODE M76</b> | Missing/incomplete/invalid diagnosis or condition.   |

Enter the patient's diagnosis/condition in Item 21 of the CMS-1500 claim form (or the equivalent electronic field). With the exception of claims submitted by ambulance suppliers (specialty type 59), all physician and non-physician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity. Enter up to four codes in priority order (primary, secondary condition).

The full ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) system consists of three volumes.

For Medicare Part B claims billed to carriers, providers should use only the first two volumes.

Volume II contains an alphabetic listing of diagnoses and conditions and shows a numeric base code for each narrative description

Volume I contains a numeric listing of codes assigned to diagnoses and conditions. This volume also contains "V" and "E" ICD-9 codes. (Medicare Part B does not recognize "E" codes.)

- Numeric codes (001.0 to 999.9) are broken down into 17 classifications of diseases and injuries.
- V codes (V01.0 to V82.9) describe circumstances of a patient visit for reasons other than disease or injury.

**The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets, including ICD-9-CM, must be date of service compliant.** This means that physicians, practitioners, and suppliers must use the current and valid diagnosis code that is in effect for the date of service being billed.

Updated ICD-9-CM codes are effective October 1 of each year. CMS posts new, revised, and discontinued codes at on the following Web site: [http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01\\_overview.asp](http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/01_overview.asp)

This Web page also includes a link to "ICD-9-CM Official Guidelines".

For additional ICD-9 Coding resources and Web Based Training (WBT), access: [http://cms.meridianksi.com/kc/main/kc\\_frame.asp?kc\\_ident=kc0001&loc=1](http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1)

## Procedure Codes

|                     |  |
|---------------------|--|
| <b>CO-16</b>        | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>REM CODE M51</b> | Missing/incomplete/invalid procedure code(s).  |

Report the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code in Item 24d or equivalent electronic field. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 (08-05) has the ability to capture up to four modifiers.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description

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in the electronic notepad or narrative or in item 19 of the paper claim form if a coherent description can be given within the confines of that box. Otherwise, an attachment shall be submitted with the claim. This is a required field.

The Health Insurance Portability and Accountability Act (HIPAA) requires that medical code sets, including HCPCS, must be date of service compliant. This means that physicians, practitioners, and suppliers must use the current and valid procedure code that is in effect for the date of service being billed.

The HCPCS is divided into two principal subsystems, referred to as level I and level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. The CPT codes are republished and updated annually by the AMA. Changes are effective January 1 of each year.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by 4 numeric digits, while CPT codes are identified using 5 numeric digits.

CMS maintains and distributes HCPCS Level II Codes. Changes are effective January 1 of each year. The level II code set can be downloaded at: [http://www.cms.hhs.gov/HCPCSReleaseCodeSets/01\\_Overview.asp](http://www.cms.hhs.gov/HCPCSReleaseCodeSets/01_Overview.asp).

## Where the Service Was Furnished

|                      |  |
|----------------------|--|
| <b>CO-16</b>         | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>REM CODE M114</b> | Missing/incomplete/invalid information on where the services were furnished.   |

Enter the name and address, and ZIP code of the service location for all services other than those furnished in place of service home – 12 in Item 32 Form CMS-1500 (08-05) or equivalent electronic field. Only one name, address and zip code may be entered in e Item 32 of the paper claim form. (The electronic claim format allows reporting of multiple service locations, specific to the line level service.)

Providers of service (namely physicians) shall identify the supplier's name, address, and ZIP code when billing for purchased diagnostic tests. When more than one supplier is used, a separate Form CMS-1500 shall be used to bill for each supplier.

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

If an independent laboratory is billing, enter the place where the test was performed.

Report the NPI of the service facility as soon as it is available using the electronic claim format or the CMS-1500 (08-05). The NPI may be reported on the Form CMS-1500 (08-05) as early as January 1, 2007, and must be reported May 23, 2007, and later.

Item 32b Form CMS-1500 (08-05) - Enter the ID qualifier 1C followed by one blank space and then the PIN of the service facility. Effective May 23, 2007, and later, 32b is not to be reported.

## Claims Processing Jurisdiction

|                      |   |
|----------------------|---|
| <b>CO-109</b>        | Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.  |
| <b>REM CODE N104</b> | This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS Web site at: <a href="http://www.cms.hhs.gov">http://www.cms.hhs.gov</a> |

Refer to CMS Online Manual, Pub.100-04, Medicare Claims Processing, Chapter 1, Section 10.1 <http://www.cms.hhs.gov/manuals> to learn more about claims processing jurisdictions.

## Clinical Laboratory Improvement Amendments (CLIA)

|                      |  |
|----------------------|--|
| <b>CO-109</b>        | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>REM CODE N120</b> | Missing/incomplete/invalid CLIA certification number   |

Report the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures in Item 23 of the CMS-1500 (08-05) or equivalent electronic field.

Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. The final CLIA regulations were published in

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the Federal Register on February 28, 1992. The requirements are based on the complexity of the test and not the type of laboratory where the testing is performed. On January 24, 2003, the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare & Medicaid Services (CMS) published final CLIA Quality Systems laboratory regulations that became effective April, 24, 2003.

CLIA requires all facilities that perform even one test, including waived tests, on "materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of, human beings" to meet certain Federal requirements. If a facility performs tests for these purposes, it is considered a laboratory under CLIA and must apply and obtain a certificate from the CLIA program that corresponds to the complexity of tests performed.

A list of waived tests can be found at: [http://www.cms.hhs.gov/CLIA/10\\_Categorization\\_of\\_Tests.asp#TopOfPage](http://www.cms.hhs.gov/CLIA/10_Categorization_of_Tests.asp#TopOfPage).

A list of state survey agencies can be found at: <http://www.cms.hhs.gov/CLIA/downloads/CLIA.SA.pdf>.

Find more information about CLIA at: <http://www.cms.hhs.gov/CLIA/>.

## Initial Treatment Date

|                       |  |
|-----------------------|--|
| <b>CO-16</b>          | Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. |
| <b>REM CODE MA122</b> | Missing/incomplete/invalid initial treatment date.   |

For chiropractic services, enter an 8-digit (MM |DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment in Item 14 of the CMS-1500 (08-05) form or equivalent electronic field. Also 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) in Item 19. By entering an x-ray date and the initiation date for course of chiropractic treatment, the chiropractor is certifying that all the relevant information requirements (including level of subluxation) of Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, are on file, along with the appropriate x-ray and all are available for carrier review.

## Time Limitations for Filing Provider Claims Claim Timely Filing Limits

Providers who furnish covered services to Medicare beneficiaries are required to file claims on behalf of their patients.

They have until the end of the calendar year following the year in which the service was furnished to file a claim, unless the service was furnished in the last three months of the year. Then the service is considered to have been furnished in the subsequent year. Fifteen months is the absolute minimum that providers have to file a claim timely, and within the Mandatory Claim Submission requirements.

In addition to claim filing deadlines, claims where assignment is taken are also subject to a ten-percent reduction in payment if the claim is not filed within 12 months of the date of service. If an assigned claim is filed beyond the 12 month allowed period, the provider is not allowed to charge the beneficiary for the ten-percent reduction.

Carriers will process submitted claims within the following time limits:

| For Services Received Between          | Claims Must Be Submitted By |
|--|-----------------------------|
| October 1, 2007 and September 30, 2008 | December 31, 2009           |
| October 1, 2008 and September 30, 2009 | December 31, 2010           |

For additional information on time limitations, refer to the CMS Manual System, Pub 100-4, Medicare Claims Processing, Chapter 1, Section 70, (<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>).