

Introduction

This specialty manual is linked to the appropriate sections of the Online CMS (Centers for Medicare & Medicaid Services) Manual System for your convenience and to assure that you always have access to the most up-to-date information on guidelines relating to this specialty.

CMS transitioned to a Web-based system in 2003. Their system is called the Online CMS Manual System and is located at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>. The Online Manual System is organized by functional area and includes guidelines affecting all of Medicare (i.e. Part A (Hospital Services, Part B (Medical Services, etc.).

To use this manual, simply locate the topic of interest and note the corresponding section of the Online CMS Manual System, then click on the link to the Online CMS Manual System. This takes you to the appropriate Publication and Chapter; you then review the Table of Contents for your specific topic/section number. Most chapters in the Online CMS Manual allow you to click on the specific section in the Table of Contents which takes you directly to that section in the chapter. Other chapters require that you scroll through the chapter to find the section noted in the specialty manual.

Disclaimer

This manual has been prepared as a tool to assist providers. Every reasonable effort has been made to assure the accuracy of the information; however, the ultimate responsibility for correct billing lies with the provider of the services.

CGS, Medicare Outreach and Education, their employees and their staff make no representation, warranty or guarantee that this compilation of Medicare information is all inclusive or error-free and will bear no responsibility for the results or consequences of the use of this manual. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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 CGS 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 CGS 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 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

CGS frequently receives calls asking why claims are reduced, denied or returned as unprocessable. In the Centers 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.

CGS		MEDICARE
P. O. BOX 671		REMITTANCE
NASHVILLE, TN 372020000		NOTICE
THE DOCTOR	NPI #:	111111116
123 THREE STREET	PAGE #:	1
SOMEWHERE, NC 372002531	DATE:	01/24/2009
	CHECK/EFT #:	11111117

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

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.

CGS PO BOX 671 NASHVILLE, TN 372020000		MEDICARE REMITTANCE NOTICE
THE DOCTOR 123 THREE STREET SOMEWHERE, NC 372002531	PROVIDER #: PAGE #: DATE: CHECK/EFT #:	111111116 1 01/24/2009 111111117

Alert: This area is reserved to communicate current alerts.

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	00000000000001	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	

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	00000000000001	ASG	Y	MOA	MA01
111111116	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.gov/manuals/downloads/clm104c26.pdf>

Incorrect Beneficiary Number

CO-16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
MOA CODE MA27	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 EDI 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

CO-16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
MOA CODE MA112	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 – Effective May 23, 2007, and later, you **MUST** enter the National Provider Identifier (NPI) of the billing provider or group.

Item 33b – 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 of the individual physician/practitioner.

If a group practice is billing, then the group NPI 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 – Effective May 23, 2007, and later, 24I is not to be reported.

Item 24J – 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

CO-16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
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REM CODE N245	Incomplete/invalid plan information for other insurance.
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Insurance Primary to Medicare

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

- 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.

For complete information on these MSP provisions, see CMS Online Manual, Pub. 100-05, Medicare Secondary Payer Manual at: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>.

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
- 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.

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 full time equivalents (FTE) 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.cgsmedicare.com/medicare_dynamic/education/OO1.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

CO-16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
REM CODE N286	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 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 15 (<http://www.cms.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;
- 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 a National Provider Identifier (NPI). An NPI must be reported even though the physician may never billed Medicare directly.

Item 17a - Effective May 23, 2007, and later, 17a is not to be reported.

Item 17b - Enter the NPI of the referring/ordering physician listed in Item 17.

NOTE: 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

CO-4	The procedure code is inconsistent with the modifier used, or a required modifier is missing.
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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.gov/Medicare/Coding/HCPCSReleaseCodeSets/>

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

CGS 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.

Use the Physician Fee Schedule search tool available at <http://www.cms.gov/apps/physician-fee-schedule/overview.aspx> to help determine which procedure codes may be submitted with modifiers to identify bilateral surgery, multiple surgery, assistant at surgery, technical/professional components, co-surgery, etc..

Place of Service

CO-16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
REM CODE M77	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 Evaluation & Management Services (CPT codes 99201 through 99215) are submitted with POS codes 11 (Office) and 22 (Outpatient Hospital), while Inpatient Evaluation & Management Services (CPT codes 99221 through 99223) are submitted with POS code 21 (Inpatient Hospital).

Other services such as 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.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf>).

Diagnosis Codes

CO-16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
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REM CODE M76	Missing/incomplete/invalid diagnosis or condition.
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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 website: <http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/index.html>

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

Procedure Codes

CO-16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
REM CODE M51	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 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.gov/Medicare/Coding/HCPCSReleaseCodeSets/>.

Where the Service Was Furnished

CO-16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
REM CODE M114	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 in Item 32 Form CMS-1500 (08-05) or equivalent electronic field. Only one name, address and zip code may be entered in 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).

Item 32b - 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

CO-109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
REM CODE N104	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 website at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf

Refer to CMS Online Manual, Pub.100-04, Medicare Claims Processing, Chapter 1, Section 10.1 <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf> to learn more about claims processing jurisdictions.

Clinical Laboratory Improvement Amendments (CLIA)

CO-109	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
REM CODE N120	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 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.gov/Regulations-and-Guidance/Legislation/CLIA/index.html>

A list of state survey agencies can be found at:

<http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf>

Find more information about CLIA at:

<http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf>

Initial Treatment Date

CO-16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
REM CODE MA122	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

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

Section 6404 of the Affordable Care Act of 2010 (ACA) amended the timely filing requirements to reduce the maximum time period for submission of all Medicare Fee-for-Service claims to one calendar year after the date of service. These amendments apply to services furnished on or after January 1, 2010.

Additionally, this section mandates that all claims for services furnished prior to January 1, 2010 had to be filed with the appropriate Medicare claims processing contractor no later than 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.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c01.pdf>).