



News Flash – The revised publication titled ICD-10-CM/PCS: An Introduction Fact Sheet (August 2009), which provides general information about the International Classification of Diseases, 10th Edition, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) including benefits of adopting the new coding system, structural differences between ICD-9-CM and ICD-10-CM/PCS, and implementation planning recommendations, is now available in print format from the Centers for Medicare & Medicaid Services Medicare Learning Network. To place your order, visit <http://www.cms.hhs.gov/MLNGenInfo/>, scroll down to “Related Links Inside CMS” and select “MLN Product Ordering Page.” For more educational resources regarding the ICD-10-CM/PCS Coding System, please visit <http://www.cms.hhs.gov/ICD10/> on the CMS website.

MLN Matters® Number: MM6670 **Revised**

Related Change Request (CR) #: 6670

Related CR Release Date: January 29, 2010

Effective Date: April 1, 2010

Related CR Transmittal #: R1903CP

Implementation Date: April 5, 2010

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

Note: This article was revised on February 1, 2010 to reflect a revised CR 6670 that was issued on January 29, 2010. Within this article, the CR release date, transmittal number, and the Web address for accessing CR 6670 were revised. All other information remains the same.

Provider Types Affected

This article is for physicians and other providers submitting claims to Medicare contractors (carriers and/or A/B Medicare Administrative Contractors (A/B MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed



STOP – Impact to You

This article is based on Change Request (CR) 6670 which provides your Medicare Contractor with instructions for processing claims for diagnostic services that are

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subject to the 'anti-markup payment limitation' and that are billed with missing or incomplete information in Item 20 of the form CMS-1500 or its electronic equivalent.



CAUTION – What You Need to Know

Prior to the implementation of the anti-markup payment limitation, contractors were instructed to assume none of the services presented on a claim were purchased if Item 20 was either not completed or was missing information. CR 6670 gives specific criteria for processing claims with partial information completed in Item 20.



GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Medicare Claims Processing Manual (Chapter 1, Section 80.3.2.1.2) establishes guidelines for processing of claims for diagnostic services when:

- There is no entry for the “Yes/No” indicator in Item 20 of the CMS-1500 claim form, or
- The ANSI X12 837P electronic claim is missing a claim or line level PS1 segment to indicate whether the diagnostic services were purchased.

Your Medicare Contractor is instructed to assume that a diagnostic service was not purchased when there is no “Yes/No” indicator marked in Item 20 of the paper claim form or its electronic equivalent. Additionally, the instructions referred to anti-markup as it was formerly known as “purchased diagnostic tests” and applied only to the technical component (TC) of a diagnostic test. (See CR 6122 (Transmittal 1589, Sep. 8, 2008) at

<http://www.cms.hhs.gov/transmittals/downloads/R1589CP.pdf> on the Centers for Medicare & Medicaid Services (CMS) website. An MLN Matters article related to that transmittal is available at

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6122.pdf> on the CMS website.)

CR 6670 provides instructions for processing claims for diagnostic services that are subject to what is now known as the 'anti-markup payment limitation' and that are billed with missing or incomplete information in Item 20 of the CMS-1500 or its electronic equivalent.

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

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

Note: In accordance with the requirements of the 'anti-markup payment limitation', Medicare Contractors will apply the above logic to both the TC and PC (professional component) of diagnostic tests

Additional Information

The official instruction, CR 6670, issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.hhs.gov/Transmittals/downloads/R1903CP.pdf> on the CMS website.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

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