CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1328	**Date: AUGUST 31, 2007**
	Change Request 5678

Subject: Delete References to Reporting of the National Provider Identifier (NPI) on or after May 23, 2007, and Revise References to a "When Required" Date.

I. SUMMARY OF CHANGES: This CR updates the IOM claims processing instructions concerning incomplete and invalid claims to delete references to the mandatory reporting of the NPI on or after May 23, 2007 on the Form CMS-1500 or electronic equivalent in accordance with the previously announced CMS contingency plan for the reporting of the NPI. References in the instruction to mandatory reporting of the NPI are revised to indicate that this must occur when the NPI reporting requirement is required. The date for mandatory reporting of the NPI will be announced in a separate Change Request. The effective date of this Change Request refers to claims received on or after the effective date.

New / Revised Material
Effective Date: October 1, 2007. The effective date applies to claims received on or after this date.
Implementation Date: October 1, 2007

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

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

R/N/D	Chapter / Section / Subsection / Title
R	1/80.3.2.1.1/Carrier Data Element Requirements
R	1/80.3.2.1.2/Conditional Data Element Requirements for Carriers and DMERCs
R	1/80.3.2.1.3/Carrier Specific Requirements for Certain Specialties/Services

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2008 operating budgets.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1328	Date: August 31, 2007	Change Request: 5678

SUBJECT: Delete References to Reporting of the National Provider Identifier (NPI) on or after May 23, 2007, and Revise References to a "When Required" Date

Effective Date: October 1, 2007. The effective date applies to claims received on or after this date.

Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: The NPI final rule, published on January 23, 2004, established the standard for a unique identifier for each health care provider for use in health care transactions. Medicare contractors were to be required to enter NPI in certain items and fields of paper claim forms and electronic equivalents on or after May 23, 2007. However, CMS has issued a contingency plan which has delayed the required use of the NPI on claims. CMS will establish a new date for required use of the NPI on claims and will announce this date in a future communication.

B. Policy: This instruction updates the incomplete and invalid claims processing instructions in the Medicare claims processing manual to delete references to the May 23, 2007, mandatory date for entry of the NPI on claims. The NPI was scheduled to be required to be used by all providers on and after May 23, 2007. However, on April 2, 2007, the Department of Health and Human Services (DHHS) provided guidance regarding contingency planning for the implementation of the NPI. For some time after May 23, 2007, Medicare FFS will allow continued use of legacy numbers (PINs and UPINs), as well as accepting transactions with only NPIs. The required date for providers to use only the NPI only on claims and to cease entering PINs and UPINs will be officially announced at a later date, as noted in Transmittal 1227, CR 5595.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5678.1	Contractors shall recognize the continued use of PINs and UPINs on Medicare claims until the NPI is required, as indicated in Publication 100-4, Chapter One, Sections 80.3.2.1.1 through 80.3.2.1.3	X	X		X	X						
5678.1.1	Contractors shall recognize that when the use of NPI is made mandatory, it shall be required to be present in required items on Medicare claims or the claims shall be returned as unprocessable.	X	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5678.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X		X	X						

IV. SUPPORTING INFORMATION

X-Ref Requirement Number	Recommendations or other supporting information:
	None

V. CONTACTS

Pre-Implementation Contact(s): Thomas L. Dorsey, CMS, 410-786-7434, Thomas.Dorsey@cms.hhs.gov

Post-Implementation Contact(s): Appropriate CMS Regional Office

VI. FUNDING

A. ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC):***
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2008 operating budgets.

B. ***For Medicare Administrative Contractors (MAC):***

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

80.3.2.1.1 - Carrier Data Element Requirements

(Rev. 1328, Issued: 08-31-07, Effective: 10-01-07, Implementation: 10-01-07)

A - Required Data Element Requirements

1 - Paper Claims

The following instruction describes certain data element formatting requirements to be followed when reporting the calendar year date for the identified items on the Form CMS-1500:

- If birth dates are furnished in the items stipulated below, then these items must contain 8-digit birth dates (MMDDCCYY). This includes 2-digit months (MM) and days (DD), and 4-digit years (CCYY).

Form CMS-1500 Items Affected by These Reporting Requirements:

Item 3 - Patient's Birth Date

Item 9b - Other Insured's Date of Birth

Item 11a - Insured's Date of Birth

Note that 8-digit birth dates, when provided, must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line.

If a birth date is provided in items 3, 9b, or 11a, and is not in 8-digit format, carriers must return the claim as unprocessable. Use remark code N329 on the remittance advice. For formats other than the remittance, use code(s)/messages that are consistent with the above remark codes.

If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b, or 11a. and the birth date is not in 8-digit format. However, if carriers use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

For certain other Form CMS-1500 conditional or required date items (items 11b, 14, 16, 18, 19, or 24A.), when dates are provided, either a 6-digit date or 8-digit date may be provided.

If 8-digit dates are furnished for any of items 11a., 14, 16, 18, 19, or 24A. (excluding items 12 and 31), carriers must note the following:

- All completed date items, except item 24A., must be reported with a space between month, day, and year (i.e., MM_DD_CCYY). On the Form CMS-1500, the space between month, day, and year is delineated by a dotted, vertical line;
- Item 24A. must be reported as one continuous number (i.e., MMDDCCYY), without any spaces between month, day, and year. By entering a continuous number, the date(s) in item 24A. will penetrate the dotted, vertical lines used to separate month, day, and year. Carrier claims processing systems will be able to

process the claim if the date penetrates these vertical lines. However, all 8-digit dates reported must stay within the confines of item 24A;

- Do not compress or change the font of the “year” item in item 24a to keep the date within the confines of item 24A. If a continuous number is furnished in item 24A. with no spaces between month, day, and year, you will not need to compress the “year” item to remain within the confines of item 24A.;
- The “from” date in item 24A. must not run into the “to” date item, and the “to” date must not run into item 24B.;
- Dates reported in item 24A. must not be reported with a slash between month, day, and year; and
- If the provider of service or supplier decides to enter 8-digit dates for any of items 11b, 14, 16, 18, 19, or 24A. (excluding items 12 and 31), an 8-digit date must be furnished for all completed items. For instance, you cannot enter 8-digit dates for items 11b, 14, 16, 18, 19 (excluding items 12 or 31), and a 6-digit date for item 24A. The same applies to those who wish to submit 6-digit dates for any of these items.

Carriers must return claims as unprocessable if they do not adhere to these requirements.

2 - Electronic Claims

Carriers must return all electronic claims that do not include an 8-digit date (CCYYMMDD) when a date is reported. They use remark code N329 on the remittance advice. For formats other than the remittance, carriers use code(s)/message(s) that are consistent with the above remark codes.

If carriers do not currently edit for birth date items because they obtain the information from other sources, they are not required to return these claims if a birth date is reported in items 3, 9b., or 11a. and the birth date is not in 8-digit format. However, if carriers do use date of birth information on the incoming claim for processing, they must edit and return claims that contain birth date(s) in any of these items that are not in 8-digit format.

B - Required Data Element Requirements

The following Medicare-specific, return as unprocessable requirements in this section and the following two sections are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Regulations implementing HIPAA require the use of National Provider Identifiers (NPIs) by covered health care providers and health plans Although not required by HIPAA, CMS is extending the requirement in include the NPI on electronic claims to paper claims submitted on the Form CMS-1500 (8/05). Carriers are referred to the Health Care Claims Professional 837 Implementation guide for requirements for professional claims subject to HIPAA, including the NPI reporting requirements.

Carriers must return a claim as unprocessable to a provider of service or supplier and use the indicated remark codes if the claim is returned through the remittance advice or notice process. In most cases, reason code 16, "Claim/service lacks information that is needed for adjudication", will be used in tandem with the appropriate remark code that specifies the missing information. Carriers use the following:

1. If a claim lacks a valid Medicare Health Insurance Claim Number (HICN) in item 1a. or contains an invalid HICN in item 1a. (Remark code MA61.)
2. If a claim lacks a valid patient's last and first name as seen on the patient's Medicare card or contains an invalid patient's last and first name as seen on the patient's Medicare card. (Remark code MA36.)
3. If a claim does not indicate in item 11 whether or not a primary insurer to Medicare exists. (Remark code MA83 or MA92.)
4. If a claim lacks a valid patient or authorized person's signature in item 12 or contains an invalid patient or authorized person's signature in item 12. (See "Exceptions," bullet number one. Remark code MA75.)
5. If a claim lacks a valid "from" date of service in item 24A or contains an invalid "from" date of service in item 24A. (Remark code M52.)
6. If a claim lacks a valid place of service (POS) code in item 24B., or contains an invalid POS in item 24B. return the claim as unprocessable to the provider or supplier, using RA remark code M77. Effective for claims received on or after April 1, 2004, on the Form CMS-1500, if a claim contains more than one POS (other than Home – 12), for services paid under the MPFS and anesthesia services.
7. If a claim lacks a valid procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D or contains an invalid or obsolete procedure or HCPCS code (including Levels 1-3, "unlisted procedure codes," and "not otherwise classified" codes) in item 24D. (Remark code M20 or M51.)

Note: Level 3 HCPCS will be going away with HIPAA.

8. If a claim lacks a charge for each listed service. (Remark code M79.)
9. If a claim does not indicate at least one day or unit in item 24G (Remark Code M53.) (Note: To avoid returning the claim as "unprocessable" when the information in this item is missing, the Carrier must program the system to automatically default to "1" unit).
10. If a claim lacks a signature from a provider of service or supplier, or their representative. (See "Exceptions," bullet number one; Remark code MA70 for a missing provider representative signature, or code MA81 for a missing physician/supplier/practitioner signature.)
11. If a claim does not contain in item 33:
    a. A billing name, address, ZIP code, and telephone number of a provider of service or supplier. (Remark code N256 or N258.)

    AND EITHER

    b. A valid PIN number or, for DMERC claims, a valid National Supplier Clearinghouse number (NPI in item 33a. of the *Form* CMS-1500 (8/05) when the NPI is *required*) for the performing provider of service or supplier who is not a member of a group practice. (Remark code N257)

OR

c. A valid group PIN (or NPI when *required*) number or, for DMERC claims, a valid National Supplier Clearinghouse number (NPI in item 33a. of the Form CMS-1500 (8/05), when the NPI is *required*) for performing providers of service or suppliers who are members of a group practice. (Remark code N257)

12. If a claim does not contain in Item 33a., Form CMS 1500 (08-05), the NPI*, when required,* of the billing provider, supplier, or group. (Remark Code N257 or MA112.)

80.3.2.1.2 - Conditional Data Element Requirements for Carriers and DMERCs

(Rev. 1328, Issued: 08-31-07, Effective: 10-01-07, Implementation: 10-01-07)

A - Universal Requirements

The following instruction describes "conditional" data element requirements, which are applicable to assigned carrier 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), carriers 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.

Carriers must return a claim as unprocessable to the supplier/provider of service:

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 UPIN (*until the NPI is required*) 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) when the NPI is *required*. (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 UPIN (*until the 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 CMS-1500 (8/05) when the NPI is required*. (Remark code N269 or N270 is used.)

c. For diagnostic tests subject to purchase price limitations:

    1. If a "YES" or "NO" is not indicated in item 20. (Remark code M12 is used.)

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

    3. If the "YES" box is checked in item 20 and the purchase price is entered under "$CHARGES", but the supplier's name, address, ZIP code, and PIN are

not entered in item 32 or if the NPI is not entered into item 32a. of the Form CMS-1500 (8/05) when the NPI is *required* when billing for purchased diagnostic tests. (Remark code N256, N257, or N258 are 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 interpretation and test 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 interpretation and test 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 has been purchased, more than one test is billed on the claim, and line level information for each total purchased service 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 has been purchased, and the service is billed using a global code rather than having each component billed as a separate line item.

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

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

f. If a performing physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner is a member of a group practice and*, until the NPI is required,* does not enter his or her PIN in item 24K of Form CMS-1500 (12-90) or if the NPI is not entered into item 24J of Form CMS-1500 (08-05) when the NPI is *required* and the group practice's PIN (NPI when *required*) in item 33. (Remark code MA112 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 one 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 contractors treat as home, must be entered according to Pub. 100-04, Chapter 1, sections 10.1.1 and 10.1.1.1. (Remark code MA114 is used.)

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

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

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services

(Rev. 1328, Issued: 08-31-07, Effective: 10-01-07, Implementation: 10-01-07)

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 their UPIN (until the NPI is required) is not present in 17a.* or if the NPI is not entered in item 17b. of the *Form* CMS-1500 (8/05) when the NPI is *required*. (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 their UPIN (until the NPI is required) is not present in 17a.* or if the NPI is not entered in item 17b. of the *Form* CMS-1500 (8/05) when the NPI *is required.* (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 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.

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 their UPIN (until the NPI is required) is not present in item 17a*. or if the NPI is not entered in item 17*b*.of the Form CMS-1500 (8/05) when the NPI is *required*). (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 UPIN (or NPI when *required*) *is* not entered in items 17 *or their UPIN (until the NPI is required) is not entered in item 17a*. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is *required*). (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 items or 17 *or their UPIN (until the NPI is required) is not entered in item 17a. or if the NPI is not entered in item 17b. of the Form CMS-1500 (8/05) when the NPI is required*. (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 the UPIN *or* NPI*, when required,* 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, providers 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 UPIN *or* NPI*, when required,* 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, and PIN *(until the NPI is required)* where the laboratory services were performed in item 32 or if the NPI is not entered into item 32a. of the Form CMS-1500 (8/05) 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. (Remark code MA50 is used.)

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 100.4.2 through 100.4.4.