
Medicare

Carriers Manual

Part 3 - Claims Process

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<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
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NEW/REVISED MATERIAL--EFFECTIVE DATE: October 1, 2002
IMPLEMENTATION DATE: October 1, 2002

Section 3005, Unprocessable Claims, has had its name changed from Incomplete or Invalid Claims and is generally revised to update the section to reflect new requirements since the last revision. An initial sentence has been added to clarify that the instruction applies to assigned claims, as had been indicated in the transmittal sheet of the previous revision, but not in the body of that instruction. This revision includes reinstatement of reference to both the Provider Identification Number (PIN) and the Unique Physician Identification Number (UPIN) along with the National Provider Identifier (NPI) because the NPI has not yet been implemented. The previous instruction refers to the NPI and does not refer to the PIN and UPIN that are in current use. The requirement to use the NPI will be effective when that project is implemented. The CMS will notify you when that has occurred. Reference to HCFA in the HCFA-1500 and other forms have been changed to CMS in order to reflect the change of the agency acronym to CMS.

In several places in the instruction where the term “reject” was found that term has been changed to “return”. Where the term “return/reject” was found, the term has been changed to “return”.

The previous instruction had referred to the numbered information elements on the paper Form CMS-1500 as “fields”. In order to conform to the term found on the reverse side of the form CMS-1500, when the word “field” was used in the previous instruction to refer to the information elements on Form CMS-1500, the term “field” has been changed to “item” or “items” in this revision.

Section 3005.1, Claims Processing Terminology, is revised to add the term “Unprocessable claim” and its definition and to add a sentence indicating that a claim returned as unprocessable through the remittance process must not be counted as a “clean claim”.

Section 3005.2, Handling Unprocessable Claims, has been revised to include reference to MCM Part 3, §§3047-3057 and to clarify language.

Section 3005.3, Data Element Requirements Matrix, has been revised to include additional information concerning reporting unprocessable claims on pages 2-9 of CROWD form T and reference to the Accredited Standards Committee X12N 837 Version 4010 implementation guide for use when HIPAA is implemented.

Section 3005.4, Data Element Requirements, is revised to include the Remittance Advice remark codes for carriers to use if returning unprocessable claims with an electronic or paper remittance advice. It is also revised to require that for item 32 of Form CMS-1500 or electronic equivalent, a zip code is to be included whenever an address is reported. This reflects the requirements currently set forth in §4020 of Part III of the Medicare Carriers Manual.

A new subparagraph A is added which requires, as previously implemented, the use of 8-digit date(s), when reported, in items 3, 9B, and 11A of Form CMS-1500 or electronic equivalent for carriers that use date of birth information on incoming paper and electronic claims for processing and the consistent use of 6-digit or 8-digit date(s) in certain other date items when these items are completed on paper claims. For electronic claims, an 8-digit date format is required for all reported dates.

In accordance with the Balanced Budget Act of 1997 §4317, the reporting of ICD-9CM codes by non-physician practitioners is required under paragraph C. Conditional Data Element Requirements.

As previously implemented, x-ray dates(s) are no longer required for chiropractic claims and a laboratory identification number must be reported in item 23 of Form CMS-1500 for each claim for laboratory services submitted by any laboratory performing tests covered by Clinical Laboratory Improvements Amendments of 1988 (CLIA).

The reference to the furnishing of the word "SAME" as an alternative to providing a name and address or PIN of the provider or facility in item 32 of Form CMS-1500 when the Place of Service (POS) is the patient's home or physician's office has been deleted. For certain services where the POS indicated on the claim is the patient's home or the physician's office, item 32 need not be completed. Certain other services, such as purchased diagnostic tests, now require a valid name, address, and zip code in item 32. When an address is furnished in item 32, a zip code is now required.

Section 3999, Exhibits, has been changed to reference version 3.01 of the National Standard Format (NSF) for electronic claims now in effect and to add references to ANSI 837 Version 4010 for use when HIPAA is implemented. For item 7, the conditional requirement that electronic claims contain an Insured's telephone number has been changed from conditional status to not required reflecting the fact this information will not be used under HIPAA. For item 20, the conditional requirement that electronic claims contain a Laboratory Indicator and a Purchased Service Indicator has been deleted to reflect the fact this will not be used under HIPAA. References to NPI have been changed to PIN or UPIN as appropriate because the NPI has not yet been implemented.

INFORM PROVIDERS OF THE CHANGES THROUGH REGULARLY SCHEDULED CARRIER NEWSLETTERS. ALSO, CONSIDER COMMUNICATING THE CHANGES THROUGH OTHER APPROPRIATE EDUCATIONAL EFFORTS, FOR EXAMPLE, INCLUDING THE CHANGES IN REGULARLY SCHEDULED WORKSHOPS AND SEMINARS.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

CHAPTER III
CLAIMS, FILING, JURISDICTION
AND DEVELOPMENT PROCEDURES

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3005. UNPROCESSABLE CLAIMS

The instructions in all of §3005 apply to Part B assigned claims. For unassigned claims, submitted by beneficiaries (Form CMS-1490S) that are incomplete or contain invalid information, suspend and develop the claim. If corrections are not received on such unassigned claims within the suspense period, or if corrections are inaccurate, deny the claim and afford appeal rights.

3005.1 Claims Processing Terminology--

o Unprocessable Claim - Any claim with incomplete or missing, required information, or any claim that contains complete and necessary information; however, the information provided is invalid. Such information may either be required for all claims or required conditionally.

o Incomplete Information - Missing, required or conditional information on a claim (e.g., no Unique Physician Identification Number (UPIN) / Provider Identification Number (PIN) or National Provider Identifier (NPI) when effective).

o Invalid Information - Complete required or conditional information on a claim which is illogical, incorrect (e.g., incorrect UPIN/PIN or NPI when effective), or no longer in effect (e.g., an expired number).

o Required - Any data element that is needed in order to process a claim (e.g., Date of Service).

o Conditional - Any data element that must be completed if other conditions(s) exist (e.g., if the insured is different from the patient, then the insured's name must be entered on a claim).

o Not Required - Any data element that is not needed by Medicare to process a claim (e.g., Patient Status).

o Return as Unprocessable - Returning a claim as unprocessable does not mean that you should physically return every claim you received with incomplete or invalid information. The term "return as unprocessable" is used to refer to the many processes utilized today for notifying the supplier or provider of service that their claim cannot be processed, and that it must be corrected or resubmitted. Some (not all) of the various techniques for returning claims as unprocessable include:

1. Incomplete or invalid information is detected at the front-end of your claims processing system. The claim is returned to the supplier or provider of service either electronically or in a hardcopy/checklist type form explaining the error(s) and how to correct the errors prior to resubmission. Claim data is not retained in the system for these returned claims. No remittance advice is issued.

2. Incomplete or invalid information is detected at the front-end of the claims processing system and is suspended and developed. Claim data is retained in the system pending correction. If corrections are submitted within a 45-day period, the claim is processed. Otherwise, the suspended portion is returned and the supplier or provider of service is notified by means of the remittance notice.

3. Incomplete or invalid information is detected within the claims processing system and is returned through the remittance process. Suppliers or providers of service are notified of any error(s) through the remittance notice and how to correct prior to resubmission. A record of the claim is retained in the system.

In short, a claim returned as unprocessable for incomplete or invalid information does not meet the criteria to be considered as a claim, is not denied, and, as such, is not afforded appeal rights. A claim returned as unprocessable through the remittance process must not be counted as a "clean claim".

3005.2 Handling Unprocessable Claims.--This instruction applies to all data elements specified, including those in §3005.4.

A. Matrix.--The matrix (see §3005.3) specifies whether a data element is required or conditional. (See §3005.1 for definitions.) The status of these data elements will affect whether or not a claim with incomplete or invalid information will be returned as unprocessable on every claim submission. Do not deny claims and afford appeal rights for incomplete or invalid information as specified in this instruction.

B. Incomplete or Invalid Claims.--

o If a data element is required, or **is conditional (a data element that is required when certain conditions exist and the conditions of use apply)** and is missing or not accurately entered in its appropriate field, return the unprocessable claim to either the supplier or provider of service.

o If a claim must be "returned as unprocessable" for incomplete or invalid information, you must, at minimum, notify the supplier or provider of service of the following information:

1. Beneficiary's Name;
2. HIC Number;
3. **Date(s) of Service;**
4. Patient Account or Control Number (only if submitted); and
5. **Explanation of Errors (e.g., Remittance Advice Reason and Remark Codes).**

NOTE: Some of the information listed above may in fact be the information missing from the claim. If this occurs, then include what is available.

Depending upon the means of return of a claim, a supplier or provider of service has two options for correcting claims "returned as unprocessable" for incomplete or invalid information. They may submit corrections either in writing, on-line, or via telephone when the claim was suspended for development, or submit as a "corrected" new claim if data from the original claim was not retained in the system, as with a front-end return, or if a remittance advice was used to return the claim. The chosen mode of submission, however, must be currently supported and appropriate with the action taken on the claim.

NOTE: The supplier or provider of service must not be denied any services, other than a review, to which they would ordinarily have access.

o If a claim or a portion of a claim is "returned as unprocessable" for incomplete or invalid information, **do** not generate a Medicare Summary Notice to the beneficiary. The notice to the provider or supplier will not contain the usual review notice, but will show each applicable error code or equivalent message.

o If you use **an electronic or paper** remittance advice to return an unprocessable claim, or a portion of an unprocessable claim:

1. The remittance **advice** must demonstrate all applicable error codes. There must be a minimum of two codes on the remittance notice (including code MA130).
2. The returned claim or portion must be stored and annotated, as such, in history, if applicable. **If you choose to suspend and develop claims, a mechanism must be in place where you can reactivate the claim or portion for final adjudication.**

C. Exceptions--The following lists some exceptions when a claim may not be "returned as unprocessable" for incomplete or invalid information.

Do not return a claim as unprocessable:

o If a patient, individual, physician, supplier, or authorized person's signature is missing, but the signature is on file, **or if the applicable signature requirements of MCM, Part 3, §3047 through §3057 have been met.** Also, do not return a claim as unprocessable where an authorization is attached to the claim (see MCM, Part 4, §2010.2) or if the signature field has any of the following statements (unless an appropriate validity edit fails):

Acceptable Statements:

1. For items 12, 13, and 31, "Signature on File" **statement** and/or a computer generated signature.
2. For items 12 and 13, Beneficiary's Name "By" Representative's Signature.
3. For item 12, "X" with a witnessed name and address. (See MCM, Part 4, §2010.2, Item 12 for appropriate instructions.)

o For all claims submitted, regardless of format, if the appropriate information for both "required" and "conditional" data element requirements is missing or inaccurate but can be supplied through internal files.

D. Special Consideration--

o If a "suspense" system is used for unprocessable claims, do not deny the claim with appeal rights if corrections are not received within the suspense period, or if corrections are inaccurate. You **must return the unprocessable claim through the remittance process, without offering appeal rights, to the provider of service or supplier.**

o **For either a paper or electronic claim, if all "required" and "conditional" claim level information that applies is complete and entered accurately, but there are both "clean" and "dirty" service line items, then split the claim and process the "clean" service line item(s) to payment and return as unprocessable the "dirty" service line item(s) to the provider of service or supplier.**

No workload count will be granted for the "dirty" service line portion of the claim returned as unprocessable. The "clean" service line portion of the claim may be counted as workload **only if it is processed through the remittance process.** You must abide by the specifications written in the **above instruction; return the "dirty" service line portion without offering appeal rights.**

o Include in the workload count claims **returned** as unprocessable through the remittance process. Under no circumstances should claims returned as unprocessable by means other than the remittance process (e.g., claims **returned** in the front-end) be reported in your workload reports submitted to CMS. You are also prohibited from moving or changing the action on an edit which will result in an unprocessable claim being **returned** through the remittance process. If your current action on an edit is to suspend and develop, return in the front or back-end or return in the mailroom, you must continue to do so. Workload is only being granted to accommodate those who have edits which currently result in a denial. As a result, workload reports should not deviate significantly from those reports prior to this instruction.

NOTE: Do not count returned claims as an appeal on resubmissions.

Special Reporting of Unprocessable Claims Returned on a Remittance Advice:

Report "claims returned as unprocessable on a remittance advice" on line 15 (Total Claims Processed) and on line 14 (subcategory Non-CWF Claims Denied) of page one of your Form CMS-1565. Although these claims are technically not denials, line 14 is the only suitable place to report them given the other alternatives. In addition, these claims should be reported as processed "not paid other" claims on the appropriate pages (pages 2-9) of CROWD Form T for the reporting month in which the claims were returned as unprocessable through the remittance process. Also, you must report such claims on Form Y of the Contractor Reporting of Operational and Workload Data (CROWD) system. Report the "number of such claims returned during the month as unprocessable on a remittance advice" under Column 1 of Form Y on a line using code "0003" as the identifier. For additional information on reporting on the Form CMS-1565, refer to MCM, Part 3, §13300ff.

If a supplier or provider of service chooses to provide missing or invalid information for a suspended claim by means of a telephone call or in writing do not report this activity as a claim processed on your Form CMS-1565. Subtract one claim count from line 3 of Form Y for the month in which this activity occurred.

For example, assume in the month of October 2001 you returned to providers 100 claims as unprocessable on remittance advices. You should have included these 100 claims in lines 14 and 15 of page 1 of your October 2001 Form CMS-1565. During this same month, assume you received new or corrected claims for 80 of the 100 claims returned during the month. These 80 claims should have been counted as claims received in line 4 of your October 2001 Form CMS-1565 page one (and subsequently as processed claims for the reporting month when final determination was made).

Also, during October 2001, in lieu of a corrected claim from providers, assume you received missing information by means of a telephone call or in writing for 5 out of the 100 claims returned during October 2001. This activity should not have been reported as new claims received (or subsequently as claims processed when adjustments are made) on your Form CMS-1565. On line 3 of Form Y for October 2001, you should have reported the number 95 (form claims returned as unprocessable through your remittance process minus 5 claims for which you received missing or invalid information by means of a telephone call or in writing).

For the remaining 15 claims returned during October 2001 with no response from providers in that same month, you should have reported on the Form CMS-1565 or Form Y, as appropriate, any subsequent activity in the reporting month that it occurred. For any of these returned claims submitted as new or corrected claims, you should have reported their number as receipts on line 4 of page one of your Form CMS-1565. For any of these returned claims where the supplier or provider of service chose to supply missing or invalid information by means of a telephone call or in writing, you should not have counted them again on your Form CMS-1565, but subtracted them from your count of returned claims reported on line 3 of Form Y for the month this activity occurred.

3005.3 Data Element Requirements Matrix.--The matrix (see §3999, Exhibit 10) specifies data elements that are required and conditional. These standard data elements are minimal requirements for processing a Part B claim. A crosswalk is present to relate Form CMS-1500 items (hardcopy) to fields/records in the NSF 3.01 (electronic) and the Accredited Standards Committee (ASC) X12N 837 Professional Version 4010X098 implementation guide for use when HIPAA is implemented.

The matrix does not specify item or field/record content and size. Refer to the printing specifications in MCM, Part 4, §2010.4 (hardcopy) or the NSF Manual (electronic) or the ASC X12N 837 Professional Version 4010X098 to build these additional edits. If a claim fails any one of these "content" or "size" edits, return the unprocessable claim to the supplier or provider of service.

NOTE: Provide a copy of the matrix listing the data element requirements, and attach a brief explanation to providers of service and suppliers. The matrix is not a comprehensive description of requirement that need to be met in order to submit a compliant transaction.

3005.4 Data Element Requirements.--

A. Requirements for Reporting Dates.--

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:

o 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, return the claim as unprocessable. Use remark code MA 52 on the remittance advice. For formats other than the remittance, use code(s)/messages that are consistent with the above remark codes.

If you do not currently edit for birth date items because you obtain the information from other sources, you 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 you do use date of birth information on the incoming claim for processing, you must edit and return claims that contain birth date(s) in any of these items which 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 11b, 14, 16, 18, 19, or 24a (excluding items 12 and 31), note the following:

o 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;

o 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. Your claims processing system 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;

o 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;

o The "from" date in item 24a must not run into the "to" date item, and the "to" date must not run into item 24b;

o Dates reported in item 24a must not be reported with a slash between month, day, and year; and

o 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.

Return claims as unprocessable if they do not adhere to these requirements.

2. Electronic Claims.--Return all electronic claims that do not include an 8-digit date (ccyymmdd) when a date is reported. Use remark code MA52 on the remittance advice. For formats other than the remittance, use code(s)/message(s) that are consistent with the above remark codes.

If you do not currently edit for birth date items because you obtain the information from other sources, you 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 you do use date of birth information on the incoming claim for processing, you must edit and return claims that contain birth date(s) in any of these items which are not in 8-digit format.

B. Required Data Element Requirements.--Return a claim as unprocessable to a provider of service or supplier; 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 which is needed for adjudication, will be used in tandem with the appropriate remark code that specifies the missing information:

1. If a claim lacks a valid Medicare Health Insurance Claim Number (HICN) in item 1A or contains an invalid HICN in item 1A. (Use 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. (Use remark code MA36.)

3. If a claim does not indicate in item 11 whether or not a primary insurer to Medicare exists. (Use 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 §3005.2C "Exceptions," bullet number one. Use 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. (Use remark code M52.)

6. If a claim lacks a valid place of service code in item 24B or contains an invalid place of service code in item 24B. (Use remark code M77.)

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. (Use remark code M20 if the HCPCS is missing, or M51 for an invalid/obsolete HCPCS.)

8. If a claim lacks a charge for each listed service. (Use remark code M79.)

9. If a claim does not indicate at least one day or unit in item 24G (Note: Program your system to automatically default to "1" unit when the information in this item is missing to avoid returning as unprocessable).

10. If a claim lacks a signature from a provider of service or supplier, or their representative. (See §3005.2C "Exceptions," bullet number one; Use 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. (Use remark code MA82.)

AND EITHER

b. A valid PIN (or NPI when effective) number or, for DMERC claims, a valid National Supplier Clearinghouse number for the performing provider of service or supplier who is not a member of a group practice. (Use remark code MA82 or M57 if another provider is involved.)

OR

c. A valid group PIN (or NPI when effective) number or, for DMERC claims, a valid National Supplier Clearinghouse number for performing providers of service or suppliers who are members of a group practice. (Use remark code MA112.)

C. Conditional Data Element Requirements.--

1. Universal Requirements.--The following instruction describes some "conditional" data element requirements which are applicable to all **assigned** Part B claims submitted on the Form CMS-1500 (hardcopy) or the NSF (electronic). This instruction is minimal and does not include all "conditional" data element requirements which are universal for processing a Part B claim.

Items from the Form CMS-1500 (hardcopy) have been provided. A crosswalk between Form CMS-1500 items and records and fields on **the NSF and ASC X12N 837 Professional Version 4010X098** is discussed in §3005.3.

NOTE: We have specified below 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), 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.

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 (or NPI when effective) is not present in item 17 or 17A. (Use remark code MA82.)

b. If a physician extender or other limited licensed practitioner refers a patient for consultative services, but the name and/or UPIN (or NPI when effective) of the supervising physician is not entered in items 17 or 17A. (Use remark code MA102.)

c. For diagnostic tests subject to purchase price limitations:

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

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

(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 when billing for purchased diagnostic tests. (Use remark code MA111.)

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

e. If modifiers "QB" and "QU" 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. (Use remark code MA115.)

f. If a performing physician, physician assistant, nurse practitioner, clinical nurse specialist, supplier/or other practitioner is a member of a group practice and does not enter his or her PIN (or NPI when effective) in item 24K and the group practice's PIN (or NPI when effective) in item 33. (Use remark code MA112.)

g. If a primary insurer to Medicare is indicated in item 11, but items 4, 6, and 7 are incomplete. (Use remark code MA64, MA85, MA86, MA87, MA88, MA89, or MA92 as appropriate for the missing piece(s) of data.)

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. (Use remark code MA85.)

i. If a HCPCS modifier must be associated with a HCPCS procedure code or if the HCPCS modifier is invalid or obsolete. (Use remark code M20 if there is a modifier but no HCPCS, or M78 if the modifier is missing or incorrect.)

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

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. (Use remark code M51.)

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 (Use remark code MA114.)

2. Claim Specific Requirements.--The following instruction describes some "conditional" requirements which are claim specific, and necessary for processing a Part B claim submitted on the form CMS-1500 (hardcopy) or the NSF or ASC X12N 837 (electronic) format. This instruction is minimal and does not include all "conditional" data element requirements. Not all "conditional" data elements apply to Medicare. The ASC X12N 837 implementation guide states when each conditional data element is required; if the condition applies, it must be used.

Items from the Form CMS-1500 have been provided. These items are referred to as records and fields, segments or data elements on electronic claims. Refer to §3005.3 for a crosswalk between Form CMS-1500 items (hardcopy) and records and fields on the NSF (electronic) and for the ASC X12N 837 Professional Version 4010X098 implementation guide for use when HIPAA is implemented.

NOTE: Some claim types covered by Part B are not included in these instructions. Also, the "SAME" requirement listed below only applies to paper claims.

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 01/01/2000. Entry of an x-ray date is not required for claims with dates of service on or after 01/01/2000.

2. If the initial date "actual" treatment occurred is not entered in item 14. (Use remark code MA122.)

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 (or NPI when effective) number is not entered in item 33 or their personal PIN (or NPI number when effective) is not entered in item 24K. (Use remark code MA112.)

c. For durable medical, orthotic, and prosthetic claims, if the name, address, and zip code of the location where the order was accepted is not entered in item 32. (Use remark code MA 114.)

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 the attending physician's PIN (or NPI when effective) is not entered in item 24K. (Use remark code MA112.)

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. (Use remark code MA114.)

e. For routine foot care claims, if the date the patient was last seen and the attending physician's PIN (or NPI when effective) is not present in item 19. (Use remark code MA104.)

f. For immunosuppressive drug claims, if a referring/ordering physician, physician's assistant, nurse practitioner, clinical nurse specialist was used and their name and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Use remark code M33 or MA102.)

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 and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Use remark code M33 or MA102.)

h. For laboratory services performed by a participating hospital-leased laboratory or independent laboratory in a hospital, clinic, laboratory, or facility other than 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. (Use remark code MA114.)

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"). (Use remark code MA116.)

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. (Use remark code MA114.)

j. For mammography "diagnostic" and "screening" claims, if a qualified screening center does not accurately enter their six-digit, FDA-approved certification number in item 32 when billing the technical or global component. (Use remark code MA128.)

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 and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Use remark code MA102.)

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 effective) are not entered in items 17 or 17A. (Use remark code MA102.)

m. For radiology and pathology claims for hospital inpatients, if the referring/ordering physician, physician assistant, nurse practitioner, clinical nurse specialist's name and/or UPIN (or NPI when effective) if appropriate are not entered in items 17 or 17A. (Use remark code MA102.)

n. For outpatient services provided by a qualified, independent physical or occupational therapist:

(1) If the UPIN (or NPI when effective) of the attending physician is not present in item 19. (Use remark code MA104.)

(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. (Use remark code MA104.)

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 (or NPI when effective) where the laboratory services were performed in item 32, if the services were performed at a location other of the patient's home. (Use remark code MA114.)

p. For all physician and non-physician specialty (PAs, NPs, CNSs, CRNAs, CNM, CP, CSW) claims, if an ICD-9CM code in item 21 is missing, invalid or truncated. (Use remark code M81.)

q. 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. (Use remark code MA51.)

r. For investigational devices billed in an FDA-approved clinical trial if an Investigational Device Exemption (IDE) number is not present in item 23. (Use remark code MA50.)

s. 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. (Use remark code MA49.)

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CLAIMS, FILING, JURISDICTION AND DEVELOPMENT PROCEDURES

EXHIBIT 10-DATA ELEMENT REQUIREMENTS MATRIX

CLAIMS WILL BE RETURNED AS UNPROCESSABLE IF THE FOLLOWING INFORMATION IS INCOMPLETE/INVALID:

CMS 1500	NSF 3.01	ANSI 837 Version 4010	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	MedicareStatus(Required or Conditional) *
1A	DA0 - 18.0	Loop 2010BA 2-015-NM109	Insured I.D. Number	Subscriber Primary Identifier	R
2	CA0 - 04.0	Loop 2010BA 2-015-NM103	Patient Name	Subscriber Last Name	R
	CA0 - 05.0	Loop 2010BA 2-015-NM104		Subscriber First Name	R
4	DA0 - 19.0	Loop 2330A 2-325-NM103	Insured Name	Other Insured Last Name	C
	DA0 - 20.0	Loop 2330A 2-325-NM104		Other Insured First Name	C
6	DA0 - 17.0	Loop 2000B 2-005-SBR02 Loop 2320 2-290-SBR02	Patient Relationship to Insured	Individual Relationship Code	C
7	DA2 - 04.0	Loop 2330A 2-332-N301	Insured's Address	Other Insured Address Line 1	C
	DA2 - 06.0	Loop 2330A 2-340-N401		Other Insured City	C
	DA2 - 07.0	Loop 2330A 2-340-N402		Other Insured State	C
	DA2 - 08.0	Loop 2330A 2-340-N403		Other Insured Zip Code	C
	DA2 - 09.0	Not Used	Insured Telephone Number		NR
8	CA0 - 17.0	Not Used	Patient Status		NR
	CA0 - 18.0	Not Used	Patient Student Status		NR
	CA0 - 19.0	Not Used	Patient Employment Status		NR
11	DA0 - 10.0	Loop 2320 2-290-SBR03	Insured's Policy Group Number	Insured Group or Policy Number	C
	DA0 - 05.0	Loop 2320 2-290-SBR09		Source of Payment	R
	DA0 - 06.0	Loop 2320 2-290-SBR05		Insurance Type Code	R
11C	DA0 - 11.0	Loop 2320 2-290-SBR04	Insurance Plan or Program Name	Other Insured Group Name	C
12	DA0 - 16.0	Loop 2300 2-130-CLM10	Patient Signature Source	Patient Signature Source Code	R
	EA0 - 13.0	Loop 2300 2-130-CLM09		Release of Information Indicator	R
14	EA0 - 07.0	Loop 2300 2-135-DTP03(439)	Date of Current Illness, etc.	Accident Date	C
	GC0 - 05.0	Loop 2300 2-135-DTP03(454) OR Loop 2400 2-455-DTP03(454)		Initial Treatment Date	C
15	EA0 - 15.0	Not Used	Patient Has Same/Similar Illness	Same/Similar Symptom Indicator	NR
	EA0 - 16.0	Loop 2300 2-135-DTP03(438) OR Loop 2400 2-455-DTP03(438) Loop 2300 2-135-DTP03(431) OR Loop 2400 2-455-DTP03(431)	Date of current illness or injury	Onset of current illness or injury	C
17	EA0 - 24.0	Loop 2310A 2-250-NM103 OR Loop 2420F 2-500-NM103	Name of Referring Provider	Referring Provider Last Name	C
	EA0 - 25.0	Loop 2310A 2-250-NM104 OR Loop 2420F 2-500-NM104		Referring Provider First Name	C
			OR		
	FB1 - 06.0	Loop 2420E 2-500-NM103		Ordering Provider Last Name	C
	FB1 - 07.0	Loop 2420E 2-500-NM104		Ordering Provider First Name	C
			OR		
17A	FB1 - 09.0	Loop 2420E 2-525-REF02(1G or	UPIN/PIN of Ordering Provider	Ordering Provider Secondary	C

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CLAIMS, FILING, JURISDICTION AND DEVELOPMENT PROCEDURES

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CLAIMS WILL BE RETURNED AS UNPROCESSABLE IF THE FOLLOWING INFORMATION IS INCOMPLETE/INVALID:

CMS 1500	NSF 3.01	ANSI 837 Version 4010	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	MedicareStatus(Required or Conditional) *
		1C)		Identifier (UPIN)	
	FB0 - 09.0	Loop 2420E 2-250-NM109(XX)	OR	Order Provider Primary Identifier (UPIN)	C
	EA0 - 20.0	Loop 2310A 2-250-NM109(XX) OR Loop 2420F 2-500-NM109(XX)	OR	Referring Provider Primary Identifier (UPIN)	C
	EA0 - 21.0	Loop 2310A 2-271-REF02(1G) OR	OR	Referring Provider Secondary Identifier (UPIN)	C
	FB1 - 13.0	Loop 2420F 2-525-REF02(1G)	OR		
19	EA1 - 16.0	Loop 2310E 2-250-NM109(XX) OR Loop 2420D 2-500-NM109(XX)	Reserved for Local Use	Supervising Provider Primary Identifier (PIN)	C
	FB1 - 21.0	Loop 2310E 2-260-REF02(1G/1C) OR Loop 2420D-2-525-REF02(1G/1C)		Supervising Provider Secondary Identifier (PIN)	C
	GC0 - 06.0	Loop 2300 2-135-DTP03(455) OR		X-Ray Date	C
	EA0 - 48.0	Loop 2400 2-455-DTP03(455) Loop 2300 2-135-DTP03(304) OR Loop 2400 2-455-DTP03(304)		Date Last Seen	C
	EA0 - 50.0	Loop 2300 2-220-CRC03(IH)		Homebound Indicator	C
	EA1 - 25.0	Loop 2300 2-135-DTP03(090/091)		Assumed and Relinquished Care Dates	C
	FA0 - 40.0	Loop 2400 2-450-CRC02(70)		Hospice Employed Provider Indicator	C
20	FB0 - 05.0	Loop 2400 2-488-PS102	Outside Lab	Purchased Service Charge	C
21	EA0 - 32.0	Loop 2300 2-231-HI01-02(BK)	Diagnosis	Principal Diagnosis Code	C
	EA0 - 33.0	Loop 2300 2-231-HI02-02(BF)		Diagnosis Code	C
	EA0 - 34.0	Loop 2300 2-231-HI03-02(BF)		Diagnosis Code	C
	EA0 - 35.0	Loop 2300 2-231-HI04-02(BF)		Diagnosis Code	C
22			Medicaid Resubmission Code		NR
23	DA0 - 14.0	Loop 2300 2-180-REF02(G1) OR Loop 2400 2-470-REF02(G1)	Prior Authorization Number	Prior Authorization or Referral Number	C
	FA0 - 34.0	Loop 2300 2-180-REF02(X4) OR Loop 2400 2-470-REF02(X4)	CLIA ID Number	CLIA Certification Number	C
	EA0 - 53.0	Loop 2310D 2-271-REF02(LU)	Care Plan Oversight (CPO) Number	CPO Number	C
	EA0 - 54.0	Loop 2300 2-180-REF02(LX)		Investigational Device Number	C
24A	FA0 - 05.0	Loop 2400 2-455-DTP03(472)	Dates of Service (s) (From date)	Service Date	R
	FA0 - 06.0	Loop 2400 2-455-DTP03(472)	Dates of Service (s) (To Date)	Service Date	C
24B	FA0 - 07.0	Loop 2300 2-130-CLM05-1 OR	Place of Service	Facility Type Code	R

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CLAIMS, FILING, JURISDICTION AND DEVELOPMENT PROCEDURES

EXHIBIT 10-DATA ELEMENT REQUIREMENTS MATRIX

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CMS 1500	NSF 3.01	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	MedicareStatus(Required or Conditional) *
		ANSI 837 Version 4010		
		Loop 2400 2-370-SV105	Place of Service Code	
24C	FA0 - 08.0	Not Used	Type of Service	NR
24D	FA0 - 09.0	Loop 2400 2-370-SV101-2 (HC)	Procedures, Services, etc.	R
	FA0 - 10.0	Loop 2400 2-370-SV101-3	Procedure Code	C
	FA0 - 11.0	Loop 2400 2-370-SV101-4	Procedure Modifier 1	C
	FA0 - 12.0	Loop 2400 2-370-SV101-5	Procedure Modifier 2	C
	FA0 - 36.0	Loop 2400 2-370-SV101-6	Procedure Modifier 3	C
24G	FA0 - 18.0	Loop 2400 2-370-SV104 (UN)	Days or Units of Service	R
			Units of Service	
			OR	
	FA0 - 19.0	Loop 2400 2-370-SV104 (MJ)	Anesthesia/Oxygen Minutes	R
24H	FB0 - 22.0	Loop 2400 2-370-SV112	Family Planning Indicator	NR
24I	FA0 - 20.0	Loop 2400 2-370-SV109	Emergency Indicator	NR
24J	FB0 - 21.0	Loop 2400 2-370-SV115	Co-pay Status Code	NR
24K	FA0 - 23.0	Loop 2310B 2-250-NM109(XX)	Reserved for Local Use	C
		OR	Rendering Provider Primary Identifier (PIN)	
	BA0 - 09.0	Loop 2420A 2-500-NM109(XX)	Rendering Provider Secondary Identifier (PIN)	C
		OR	Medicare Assignment Code	
27	EA0 - 36.0	Loop 2300 2-130-CLM07	Accept Assignment	NR
31	EA0 - 37.0	Loop 2300 2-130-CLM06	Provider Signature Indicator	R
32	EA0 - 39.0	Loop 2310D 2-250-NM103	Facility Name and Address	C
			Laboratory or Facility Name	
			AND/OR	
	EA1 - 04.0	Loop 2310D 2-250-NM109(XX)	Laboratory or Facility Primary Identifier (PIN)	C
		OR	Laboratory or Facility Secondary Identifier (PIN)	
		OR	Laboratory or Facility Primary Identifier (PIN)	
		OR	Laboratory or Facility Secondary Identifier (PIN)	
	FB0 - 11.0	Loop 2310C 2-250-NM109(XX)	Purchased Service Provider Primary Identifier (PIN)	C
		OR	Purchased Service Provider Secondary Identifier (PIN)	
		OR	Mammography Certification Number	
		OR	Mammography Certification Number	
	FA0 - 31.0	Loop 2300 2-180-REF02(EW)	Mammography Certification Number	C
		OR	Mammography Certification Number	
		OR	Mammography Certification Number	
33	BA0 - 19.0	Loop 2010AA 2-015-NM103(85,1)	Provider's Billing Name & Address	R
	BA0 - 20.0	Loop 2010AA 2-015-NM104	Provider's Billing Name & Address	R
			OR	
	BA0 - 18.0	Loop 2010AA 2-015-NM103(85,2)	Payer Organization Name	R
	BA1 - 13.0	Loop 2010AA 2-025-N301	Pay-To Provider Address 1	R
	BA1 - 15.0	Loop 2010AA 2-030-N401	Pay-To Provider City Name	R
	BA1 - 16.0	Loop 2010AA 2-030-N402	Pay-To Provider State Code	R

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CLAIMS, FILING, JURISDICTION AND DEVELOPMENT PROCEDURES

EXHIBIT 10-DATA ELEMENT REQUIREMENTS MATRIX

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CMS 1500	NSF 3.01	PAPER ITEM DESCRIPTION	EDI DATA ELEMENT DESCRIPTION	MedicareStatus(Required or Conditional) *
		ANSI 837 Version 4010		
	BA1 - 17.0	Loop 2010AA 2-030-N403	Pay-To Provider Zip Code	R
	BA1 - 18.0	Loop 2010AA 2-040-PER04	Communication Number	R
		OR		
	BA0 - 09.0	Loop 2010AA 2-015-NM109(XX)	Provider's Billing Name & Address	R
	BA0 - 02.0	Loop 2010AA 2-035-REF02(1C)	Billing Provider Primary Identifier (PIN)	R
	CA0 - 28.0		Billing Provider Secondary Identifier (PIN)	C

* R = Required - information which MUST always be on a claim.

* C = Conditional - information which is required on a claim if certain conditions exist.

NR = Not Required - information which is either optional or is not required in order to process a claim.