
CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal 47

Date: DECEMBER 19, 2003

CHANGE REQUEST 2956

I. SUMMARY OF CHANGES: This instruction manualizes the return as unprocessable requirements concerning ICD-9-CM diagnosis coding for Medicare Part B claims previously released in Program Memorandum Transmittal B-03-045, Change Request (CR) 2725, dated June 6, 2003. Chapter 1, section 80.3.2.1.1 is revised to include a sentence stating that the requirements are in addition to requirements established under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Chapter 1, section 80.3.2.1.3 subparagraph p. is deleted and following subparagraphs redesignated accordingly.

NOTE: Chapter 26, Completing and Processing Form CMS-1500 Data Set, of the Medicare Claims Processing Manual will further incorporate the provisions of CR 2725 when that chapter is next revised.

NEW/REVISED MATERIAL-EFFECTIVE DATE: October 1, 2003

IMPLEMENTATION DATE: January 20, 2004

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.

II. CHANGES IN MANUAL INSTRUCTIONS: (R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/80.3.2.1.1/Carrier Data Element Requirements
R	1/80.3.2.1.3/Carrier Specific Requirements for Certain Specialties/Services

III. FUNDING: Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification

Business Requirements

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I. GENERAL INFORMATION

A. Background: The Medicare Carriers Manual return as unprocessable instructions had provided in two subparagraphs that claims for physician and nonphysician specialty claims, and for other services where required, must submit diagnosis code(s) in item 21 of the CMS-1500 claim form or electronic equivalent. If the code(s) was missing, incorrect, or truncated, the claim was to be returned by the carrier as unprocessable. Change Request (CR) 2725, Transmittal B-03-045, June 6, 2003 requires that valid diagnosis code(s) must be submitted for all claims with the exception of claims submitted by ambulance suppliers. Thus, CR 2725 had expanded the types of services where valid diagnosis codes were required on claims.

B. Policy: Effective for claims with dates of service on or after October 1, 2003, carriers must return Form CMS-1500 paper claims or electronic equivalent claims as unprocessable where a claim is required to have ICD-9-CM diagnosis code(s) on the claim but required diagnosis code(s) are not entered on the claim. This policy was set forth in CR 2725.

C. Provider Education: None

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement

"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
1	Carriers shall return paper and electronic claims with dates of service on or after October 1, 2003 as unprocessable for all specialty types that require diagnosis code(s) on the claim where the claim does not have valid diagnosis code(s). All specialty types except 59, ambulance, require diagnosis code(s) on the claim.	Carrier

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. OTHER CHANGES: N/A

Citation	Change

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2003 Implementation Date: January 20, 2004 Pre-Implementation Contact(s): appropriate CMS regional office Post-Implementation Contact(s): Appropriate regional office	These instructions should be implemented within your current operating budget
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80.3.2.1.1 - Carrier Data Element Requirements

(Rev. 47, 12-19-03)

B3-3005.4

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. They 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 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 11b, 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 MA52 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).

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 if the HCPCS is missing, or M51 for an invalid/obsolete HCPCS.)

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 (Note: To avoid returning the claim as "unprocessable" when the information in this item is missing, the FI 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 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. (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. (Remark code MA112.)

80.3.2.1.3 - Carrier Specific Requirements for Certain Specialties/Services

(Rev.47, 12-19-03)

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 (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. (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 the attending physician’s PIN (or NPI when effective) is not entered in item 24K. (Remark code MA112 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 effective) is not present in item 19. (Remark code MA104 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 and/or

UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code M33 or MA102 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 and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code M33 or MA102 is used.)
- 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. (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 and/or UPIN (or NPI when effective) is not present in items 17 or 17A. (Remark code MA102 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 effective) are not entered in items 17 or 17A. (Remark code MA102 is used.)
- 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. (Remark code MA102 is used.)

- 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. (Remark code MA104 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 MA104 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 (or NPI when effective) where the laboratory services were performed in item 32, 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 MA51 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.)