CMS Manual System

Department of Health & Human Services (DHHS)

Pub. 100-04 Medicare Claims Processing

Centers for Medicare & Medicaid Services (CMS)

Transmittal 145 | **Date: APRIL 23, 2004**

CHANGE REQUEST 3164

I. SUMMARY OF CHANGES: This instruction deletes the Data Element Requirements Matrix for carriers from chapter 1 and chapter 26. This matrix was originally published as a partial crosswalk to relate Form CMS-1500 hardcopy blocks to fields/records of NSF electronic claims. The matrix utility was found to be limited by its incomplete scope and by its being now outdated as electronic formatting requirements have changed. It is also being eliminated in order to avoid inconsistency with the Medicare Claims Processing Manual text. section 10.1 of chapter 26 has been renamed and revised to eliminate redundant text already found in chapter 1.

NEW/REVISED MATERIAL - EFFECTIVE DATE: May 24, 2004
***IMPLEMENTATION DATE: May 24, 2004**

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

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/ Table of Contents
R	1/ 80.3.2.1/Data Element Requirements Matrix
R	1/ Exhibit 1/Data Element Requirements Matrix (FI)
D	1/ Exhibit 2/Data Element Requirements Matrix (FI)
R	26/ Table of Contents
R	26/ 10.1/Claims That Are Incomplete or Contain Invalid Information
R	26/ 20/Paper Claims
D	26/30/Form CMS-1500 – Data Element Matrix

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 145	Date: April 23, 2004	Change Request 3164

SUBJECT: Data Element Requirements Matrix - Carrier

I. GENERAL INFORMATION

A. Background: This manual change deletes outdated and redundant material currently in the manual.

B. Policy: The outdated material was of limited usefulness and is therefore deleted.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3164.1	The existing Data Element Requirements Matrix – carrier shall be removed from the Medicare Claims Processing Manual.	CMS

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. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: May 24, 2004 **Implementation Date:** May 24, 2004 **Pre-Implementation Contact(s):** Thomas Dorsey at (410) 786-7434 or Tdorsey@cms.hhs.gov **Post-Implementation Contact(s):** Thomas Dorsey at (410) 786-7434 or Tdorsey@cms.hhs.gov	**These instructions shall be implemented within your current operating budget.**

Medicare Claims Processing Manual

Chapter 1 - General Billing Requirements

Table of Contents

(Rev. 145, 04-23-04)

Exhibit 1 – Data Element Requirements Matrix (FI)

80.3.2.1 - Data Element Requirements Matrix

(Rev. 145, 04-23-04)

A3-3605.3

The matrix (See Exhibit 1) specifies data elements, which are required, not required, and conditional for FI claims. The matrix does not specify item or field/record content and size. Refer to §80.3.2.1.1 and the electronic billing instructions (UB-92 and ANSI 837) on the CMS Web site to build these additional edits. If a claim fails any one of these "content" or "size" edits, the FI returns the unprocessable claim to the supplier or provider of service.

The FIs must 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.

Exhibit 1 – Data Element Requirements Matrix (FI)

(Rev. 145, 04-23-04)

A3-3600, Addendum L

Claims will be returned to the provider (RTP) if the following information is incomplete/invalid:

EMC Loop: Segment: Element*	***Paper Form Locator***	***Data Elements Description***	***Hospital***							***SNF***		
			I	***O***	***H***	***C/OP***	***RHC FQHC***	***HH***	***RD***	***I***	***O***	***RN***
2010AA all segments	*1*	*Provider Name, Address, Phone #*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*
n/a	*2*	*Untitled*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*
2300:CLM01	*3*	*Patient Control Number*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*
2300:CLM05	*4*	*Type of Bill*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*
2010AA:NM108	*5*	*Federal Tax Number*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*
2300:DTP03:434 qualifier	*6*	*Statement Covers Period (from-through)*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*
2300:QTY01:CA qualifier	*7*	*Covered Days*	*R*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*R*	*NR*	*R*
2300:QTY01:NA qualifier	*8*	*Noncovered Days*	*R*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*R*	*NR*	*R*
2300:QTY01:CD qualifier	*9*	*Coinsurance Days*	*R*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*C*	*NR*	*C*
2300:QTY01:LA qualifier	*10*	*Lifetime Reserve Days*	*R*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*C*	*NR*	*C*
n/a	*11*	*Untitled*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*	*NR*
2010CA:NM103:QC qualifier	*12*	*Patient's Name*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*
2010CA:N301	*13*	*Patient's Address*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*
2010CA:DMG02:D8 qualifier	*14*	*Patient's Birthdate*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*
2010CA:DMG03:D8 qualifier	*15*	*Patient Sex*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*	*R*

EMC Loop: Segment: Element*	Paper Form Locator	Data Elements Description	Hospital							SNF		
			I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
not used	16	Patient's Marital Status	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:DTP03:435 qualifier	17	Admission Date	R	NR	R	NR	NR	R	NR	R	NR	R
2300:DTP03:435 qualifier	18	Admission Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:CL101	19	Type of Admission	R	NR	NR	NR	NR	NR	NR	R	NR	R
2300:CL102	20	Source of Admission	R	R	NR	NR	NR	R	NR	R	NR	R
2300:DTP03:096 qualifier	21	Discharge Hour	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:CL103	22	Patient Status	R	R	R	NR	NR	R	NR	R	R	R
2300:REF02:EA qualifier	23	Medical Record Number	C	C	C	C	C	C	C	C	C	C
2300:HI01:BG qualifier	24-30	Condition Codes	C	C	C	C	C	C	C	C	C	C
n/a	31	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BH	32-35	Occurrence Codes and Dates	C	C	C	C	C	C	C	C	C	C
2300:HI01:BI	36	Occurrence Span Code and Dates	C	C	C	C	C	C	C	C	C	C
2300:REF02:F8 qualifier	37	Internal Control # (ICN)/Document Control # (DCN)	C	C	C	C	C	C	C	C	C	C
2010BD all segments	38	Responsible Party Name and Address	C	C	C	C	C	C	C	C	C	C
2300:HI01:BE qualifier	39-41	Value Codes and Amounts	C	C	C	C	C	C	C	C	C	C
2400:SV201	42	Revenue Code	R	R	R	R	R	R	R	R	R	R
n/a	43	Revenue Description	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2400:SV202	44	HCPCS/HIPPS/Rates	C	C	C	C	C	C	C	C	C	C
2400:DTP03	45	Service Date	NR	C	C	C	C	C	C	NR	C	C
2400:SV205	46	Service Units	R	R	R	R	R	R	R	R	R	R
2400:SV203	47	Total Charges	R	R	R	R	R	R	R	R	R	R
2400:SV207	48	Noncovered Charges	C	C	C	C	C	C	C	C	C	C
n/a	49	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2010BC:NM103	50	Payer Identification	R	R	R	R	R	R	R	R	R	R

EMC Loop: Segment: Element*	Paper Form Locator	Data Elements Description	Hospital							SNF		
			I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2010AA:REF01:1A qualifier	51	Provider Number	R	R	R	R	R	R	R	R	R	R
2300:CLM09	52	Release of Information	R	R	R	R	R	R	R	R	R	R
2300:CLM08	53	Assignment of Benefits Certification Indicator	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:AMT02:C5 qualifier	55	Estimated Amount Due	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
n/a	56	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
n/a	57	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2010AA:NM103:IL qualifier	58	Insured's Name	R	R	R	R	R	R	R	R	R	R
2320:SBR02	59	Patient's Relationship to Insured	C	C	C	C	C	C	C	C	C	C
2010:NM109	60	Certificate/Social Security #/HI Claim/Identification #	R	R	R	R	R	R	R	R	R	R
2320:SBR04	61	Group Name	C	C	C	C	C	C	C	C	C	C
2000:SBR02	62	Insurance Group Number	C	C	C	C	C	C	C	C	C	C
2300:REF02	63	Treatment Authorization Number	NR	NR	NR	NR	NR	R	NR	NR	NR	NR
2320:SBR01	64	Employment Status Code	C	C	C	C	C	C	C	C	C	C
2320:SBR01	65	Employer Name	C	C	C	C	C	C	C	C	C	C
2320:SBR01	66	Employer Location	C	C	C	C	C	C	C	C	C	C
2300:HI01:BK qualifier	67	Principal Diagnosis Code	R	R	R	R	R	R	R	R	R	NR
2300:HI01:BF qualifier	68-75	Other Diagnosis Codes	C	C	C	C	C	C	C	C	C	NR
2300:HI02:BJ qualifier	76	Admitting Diagnosis	R	NR	NR	NR	NR	NR	NR	R	NR	NR
2300:HI03:BN qualifier	77	E-Code	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
n/a	78	Untitled	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
n/a	79	Procedure Coding Method	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BP qualifier	80	Principal Procedure Code	C	NR	NR	NR	NR	NR	NR	NR	NR	NR
2300:HI01:BO qualifier	81	Other Procedure Codes and Dates	C	NR	NR	NR	NR	NR	NR	NR	NR	NR

EMC Loop: Segment: Element*	Paper Form Locator	Data Elements Description	Hospital							SNF		
			I	O	H	C/OP	RHC FQHC	HH	RD	I	O	RN
2310A:NM101:71 qualifier	82	Attending/Referring Physician I.D.	R	R	R	R	R	R	R	R	R	NR
2310B:NM103:72 qualifier	83	Other Physician I.D. (1)	C	C	C	C	C	NR	C	C	C	NR
2310C:NM103:73 qualifier	83	Other Physician I.D. (2)	C	C	C	C	C	NR	C	C	C	NR
2010:N301	84	Remarks	C	C	C	C	C	C	C	C	C	C
n/a	85	**Provider Representative Signature	R	R	R	R	R	NR	R	R	R	R
n/a	86	**Date	R	R	R	R	R	NR	R	R	R	R

** -- Includes qualifier if segment and element are repeated in the same loop*

*** -- Required only for hardcopy*

KEY:

R=Required; NR=Not required; C=Conditional

These indicators represent Medicare requirements only. Additional data elements may be required by the 837 claim implementation guide.

Hospital: I=Inpatient and O=Outpatient; H=Hospice; C/OP=CORF/CMHC/Outpatient Physical Therapy

RH/FQ=Independent Rural Health Clinics/Free--Standing Federally Qualified Health Centers

HH=Home Health Agency; RD=Renal Dialysis Facility (Nonhospital Operated)

Skilled Nursing Facility: I=Inpatient and O=Outpatient; RN=Religious Nonmedical Health Care Institution

Medicare Claims Processing Manual

Chapter 26 - Completing and Processing Form CMS-1500 Data Set

T

Table of Contents

(Rev. 145, 04-23-04)

10.1 - Claims That Are Incomplete or Contain Invalid Information

20 - Paper Claims

10.1 – Claims That are Incomplete or Contain Invalid Information

(Rev. 145, 04-23-04)

If a claim is submitted with incomplete or invalid information, it may be returned to the submitter as unprocessable. See Chapter 1 for definitions and instructions concerning the handling of incomplete or invalid claims.

20 – Paper Claims

(Rev. 145, 04-23-04)

B3-3002, B3-4020, B4-2010, B3-3002, B3-3003, B3-3042, B3-7563

The Form CMS-1500 (Health Insurance Claim Form) is the prescribed form for billing of Medicare, Part B covered services by noninstitutional providers and suppliers. The Form CMS-1500 can be used for both assigned and non-assigned claims, and is sometimes referred to as the AMA form. It can be purchased in any version required i.e., single sheet, snap-out, continuous. Forms can be purchased from the U.S. Government Printing Office (call 202-512-1800). An electronic version is available at http://www.cms.hhs.gov/providers/edi/edi5.asp.

Form CMS-1490S (Patient's Request for Medicare Payment)

This form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains only the first six comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Some enrollees may want to keep the original itemized physician and supplier bills for income tax or complementary insurance purposes. Photocopies of itemized bills are acceptable for Medicare deductible and payment purposes if there is no evidence of alteration. Social Security offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims.

Although §1848(g)(4) of the Act requires physicians and suppliers to submit Part B Medicare claims for services furnished on or after September 1, 1990, contractors continue to accept, process, and pay for covered services submitted by beneficiaries on a Form CMS-1490S if there is no clear indication that the service provider intends to file a claim. An itemized bill for services on or after September 1, 1990, which clearly indicates the physician or supplier intends to file a Part B claim for the patient, may be returned to the beneficiary.

For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so or if one of the following situations applies:

- *DME purchases from private sources;*
- *Cases in which a physician/supplier does not possess information essential for filing a MSP claim. Assume this is the case if the beneficiary files a MSP claim and encloses the primary insurer's payment determination notice and there is no indication that the service provider was asked to file but refused to do so;*
- *Services paid under the indirect payment procedure;*

- *Foreign claims;*

- *Services furnished by sanctioned physicians and suppliers which are approved for payment to the beneficiary per the Program Integrity Manual (PIM); and*

- *Other unusual or unique situations that are evaluated on a case-by-case basis.*

If the contractor approves 11 or more Form CMS-1490S claims in a calendar month for services performed on or after September 1, 1990, by the same physician or supplier, monitor the provider's claims submissions and take appropriate action.

The contractor continues to stock Form CMS-1490S and, upon request, furnish beneficiaries with these forms. (Beneficiaries need these forms to file claims for services that physicians/suppliers are not required to submit (e.g., services prior to September 1, 1990), or refuse to submit to Part B on their behalf.)