CMS Manual System

Pub. 100-04 Medicare Claims Processing

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

Transmittal 505 **Date: MARCH 17, 2005**

CHANGE REQUEST 3500

NOTE: Transmittal 443, dated January 21, 2005 is rescinded and replaced with Transmittal 505, dated March 17, 2005. The effect date provision at the bottom of transmittal sheet and at the end the Business Requirements Attachment was changed from date of service to date of receipt. All other information remains the same.

SUBJECT: Unprocessable Unassigned Form CMS-1500 Claims

I. SUMMARY OF CHANGES: This instruction adds text to an existing Medicare Claims Processing manual section to require that unassigned Form CMS-1500 Medicare Part B claims or electronic data interchange equivalents that are submitted with incomplete or invalid information shall be returned as unprocessable.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: July 1, 2005
IMPLEMENTATION DATE: July 5, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. 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 not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/80.3.1/ Incomplete or Invalid Claims Processing Terminology

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

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

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

Attachment - Business Requirements

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SUBJECT: Unprocessable Unassigned Form CMS-1500 claims

I. GENERAL INFORMATION

A. Background: The Medicare Claims Processing Manual, Chapter 1, Sections 80.3.1 and following sections provide instructions for handling Medicare claims, including Part B Form CMS-1500 claims that have incomplete or invalid information. Such claims are to be returned without appeal rights. With respect to CMS-1500 claims, these instructions currently are specified to apply to only assigned claims. The instructions have been silent as to unassigned CMS-1500 claims. As a result, many Part B carriers and DMERCs have been denying unassigned CMS-1500 claims with appeal rights and not returning these claims as unprocessable without appeal rights. When denying these claims, contractors have been sending electronic crossover claims to COB secondary payers that contain HIPAA noncompliant claims data such as diagnosis codes and procedure codes that are not part of the standard code sets. Under HIPAA rules, the COB trading partners are not required to process claims that are not HIPAA compliant. In claims with multiple service lines, the entire claim might be rejected. The inclusion of HIPAA noncompliant data has resulted in some COB trading partners refusing to process such crossover claims for Medicare beneficiaries.

B. Policy: Apply the current provisions of the Incomplete and Invalid claims Instruction in Chapter 1 of the Medicare Claims Processing Manual to unassigned Form CMS-1500 claims or electronic data interchange equivalent submitted by Medicare providers. This will result in unassigned Form CMS-1500 claims, as well as assigned Form CMS-1500 claims, or electronic data interchange (EDI) equivalent, that have incomplete or invalid data, including data governed by HIPAA requirements, being returned as unprocessable to the submitters for correction or resubmission. When the claims are corrected and then processed, electronic crossover claims can be sent to COB trading partners that are HIPAA compliant and the COB secondary payer claims can be processed for Medicare beneficiaries.

C. Provider Education: A Medlearn Matters provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn 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 one week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility (“X” indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3500.1	Medicare contractors shall return unassigned Form CMS-1500 claims or EDI equivalent as unprocessable where the claims are incomplete or contain invalid information, in accordance with the requirements of Chapter 1, Section 80.3.1 ff. of the Medicare Claims Processing Manual.			**X**	**X**		**X**	**X**		
3500.2	Medicare contractors shall continue to suspend and develop unassigned Form CMS-1490S claims submitted by beneficiaries where the claims are incomplete or contain invalid information, in accordance with the requirements of Chapter 1, Section 80.3.1 of the Medicare Claims Processing Manual.			**X**	**X**		**X**	**X**		
3500.3	Medicare contractors shall hold claims received on July 1, 2005 through July 4, 2005 and not process them until July 5, 2005, the implementation date of this CR 3500.			**X**	**X**		**X**	**X**		

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*: July 1, 2005 **Implementation Date:** July 5, 2005 **Pre-Implementation Contact(s):** Thomas Dorsey (410) 786-7434 **Post-Implementation Contact(s):** Appropriate CMS Regional Office	**Medicare contractors shall implement these instructions within their current operating budgets.**

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80.3.1 - Incomplete or Invalid Claims Processing Terminology

(Rev. 505, Issued: 03-17-05, Effective: 07-01-05, Implementation: 07-05-05)

The following definitions apply to §80.3.2. For carriers the requirements apply to Part B assigned *and unassigned claims (Form CMS-1500) or electronic data interchange equivalent.* For unassigned claims submitted by beneficiaries (Form CMS-1490S), that are incomplete or contain invalid information, carriers suspend and develop the claim. If corrections are not received on such unassigned claims within the suspense period, or if corrections are inaccurate, carriers deny the claim and afford appeal rights.

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.

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).

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

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

Not Required - Any data element that is optional or is not needed by Medicare in order to process a claim (e.g., Patient's Marital Status).
Conditional - Any data element that must be completed if other conditions exist (e.g. if there is insurance primary to Medicare, then the primary insurer's group name and number must be entered on a claim or if the insured is different from the patient, then the insured's name must be entered on a claim).

Return as Unprocessable or Return to Provider (RTP)- Returning a claim as unprocessable to the provider (RTP) does not mean that the carrier or FI should physically return every claim it received with incomplete or invalid information. The term "return to provider" is used to refer to the many processes utilized today for notifying the provider or supplier 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:

- Incomplete or invalid information is detected at the front-end of the carrier or FI claims processing system. The claim is returned to the provider (RTP'd) either electronically or in a hardcopy/checklist type form explaining the error(s) and how to correct the errors prior to resubmission. Claim data are not retained in the system for these RTPed claims. No RA is issued.
- Incomplete or invalid information is detected at the front-end of the claims processing system and is suspended and developed. If requested corrections

and/or medical documentation 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 RA.

- Incomplete or invalid information is detected within the claims processing system and is rejected 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 (Note: This applies to carriers only. FIs do not use the remittance advice process for return to provider (RTPs)).

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.