

## Elements of a Clean Claim

1. **Clean claim defined.** A clean claim has no defect, impropriety or special circumstance, including incomplete documentation that delays timely payment. A provider submits a clean claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements, or revisions to data elements, attachments and additional elements, of which the provider has knowledge. Claims for inpatient and facility programs and services are to be submitted on the UB-04 and claims for individual professional procedures and services are to be submitted on the CMS-1500. In addition, claims may be submitted electronically through a contracted clearinghouse or on Magellan's Web-based claims submission application. Magellan does not typically, but may require attachments or other information in addition to these standard forms (as noted below). Magellan may request treatment records for review.
2. **Required clean claim elements.** The Center for Medicare and Medicaid Services (CMS) developed claim forms that record the information needed to process and generate provider reimbursement. The CMS-1500 form (revised August 2005 version) is for use by outpatient providers such as physicians, radiologists and other non-institutional providers. The required elements of a clean claim must be complete, legible and accurate.

### CMS-1500

In the following line item description, the parenthetical information following each term is a reference to the field number to which that term corresponds on the CMS-1500 claim form.

- Subscriber's/patient's plan ID number (field 1a);
- Patient's name (field 2);
- Patient's date of birth and gender (field 3);
- Subscriber's name (field 4);
- Patient's address (street or P.O. Box, city, zip) (field 5);
- Patient's relationship to subscriber (field 6);
- Subscriber's address (street or P.O. Box, City, Zip Code) (field 7);
- Whether patient's condition is related to employment, auto accident, or other accident (field 10);
- Subscriber's policy number (field 11);
- Subscriber's birth date and gender (field 11a);
- HMO or preferred provider carrier name (field 11c);
- Disclosure of any other health benefit plans (field 11d);
- Patient's or authorized person's signature or notation that the signature is on file with the physician or provider (field 12);
- Subscriber's or authorized person's signature or notation that the signature is on file with the physician or provider (field 13);
- Date of current illness, injury, or pregnancy (field 14);
- First date of previous, same or similar illness (field 15);
- Name of Referring Provider or Other Source (field 17);
- Referring Provider NPI Number (field 17b);

- Diagnosis codes or nature of illness or injury (current ICD-9 codes are required) (field 21);
- Date(s) of service (field 24A);
- Place of service codes (field 24B);
- EMG (field 24C);
- Procedure/modifier code (current CPT or HCPCS codes are required) (field 24D);
- Diagnosis code (ICD-9) by specific service (field 24E);
- Charge for each listed service (field 24F);
- Number of days or units (field 24G);
- Rendering provider NPI (field 24J);
- Physician's or provider's federal taxpayer ID number (field 25);
- Total charge (field 28);
- Signature of physician or provider that rendered service, including indication of professional license (e.g., MD, LCSW, etc.) or notation that the signature is on file with the HMO or preferred provider carrier (field 31);
- Name and address of facility where services rendered (if other than home or office) (field 32);
- The service facility Type 1 NPI (if different from main or billing NPI) (field 32a);
- Physician's or provider's billing name and address (field 33); and
- Main or billing Type 1 NPI number (field 33a).

#### **UB-04**

The UB-04 form (previously known as the UB-92 and CMS-1450 claim forms) captures essential data elements for providers of services in institutional/inpatient/facility settings. The form can be used to bill Medicare fiscal intermediaries, Medicaid state agencies and health plans/insurers. The required elements of a clean claim must be complete, legible and accurate.

In the following line item description, the parenthetical information following each term is a reference to the field number to which that term corresponds on the UB-04 claim form.

- Provider's name, address and telephone number (field 1);
- Patient control number (field 3);
- Type of bill code (field 4);
- Provider's federal tax ID number (field 5);
- Statement period (beginning and ending date of claim period) (field 6);
- Patient's name (field 8);
- Patient's address (field 9);
- Patient's date of birth (field 10);
- Patient's gender (field 11);
- Date of admission (field 12);
- Admission hour (field 13);
- Type of admission (e.g. emergency, urgent, elective, newborn) (field 14);
- Source of admission code (field 15);
- Patient-status-at-discharge code (field 17);
- Value code and amounts (fields 39-41);
- Revenue code (field 42);
- Revenue/service description (field 43);
- HCPCS/Rates (current CPT or HCPCS codes are required) (field 44);

- Service date (field 45), (required for each date of facility-based non-inpatient services or itemization in a separate attachment is required);
- Units of service (field 46);
- Total charge (field 47);
- HMO or preferred provider carrier name (field 50);
- Type 2 main NPI number (field 56);
- Subscriber's name (field 58);
- Patient's relationship to subscriber (field 59);
- Insured's Unique ID (field 60);
- Principal diagnosis code (current ICD-9 codes are required) (field 67);
- Rendering provider Type 1 NPI (field 76-79); and
- Attending physician ID (field 76-79).

3. **Data elements.** Unless otherwise agreed by contract, the data elements contained in this paragraph are necessary for claims filed by physicians or providers if circumstances exist which render the data elements applicable to the specific claim being filed. The applicability of any given data element contained in this paragraph is determined by the situation from which the claim arose.

- (1) Other insured's or enrollee's name (CMS-1500, field 9), is applicable if patient is covered by more than one health benefit plan. If the essential data element specified in CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.
- (2) Other insured's or enrollee's policy/group number (CMS-1500, field 9a), is applicable if patient is covered by more than one health benefit plan. If the essential data element specified in paragraph CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.
- (3) Other insured or enrollee date of birth (CMS-1500, field 9b), is applicable if patient is covered by more than one health benefit plan. If the essential data element specified in paragraph CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.
- (4) Other insured or enrollee plan name (employer, school, etc.) (CMS-1500, field 9c), is applicable if patient is covered by more than one health benefit plan. If the essential data element specified in CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.
- (5) Other insured or enrollee HMO or insurer name. If the essential data element specified in CMS-1500, field 11d, "disclosure of any other health benefit plans", is answered yes, this is applicable.
- (6) Subscriber's plan name (employer, school, etc.) (CMS-1500, field 11b) is applicable if the health benefit plan is a group plan;
- (7) Prior authorization number (CMS-1500, field 23), is applicable when prior authorization is required;
- (8) Whether assignment was accepted (CMS-1500, field 27), is applicable when assignment has been accepted;
- (9) Amount paid (CMS-1500, field 29), is applicable if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber or by a primary plan (Commercial or Medicare). When applicable, a copy of the primary plan's EOB is required;

- (10) Balance due (CMS-1500, field 30), is applicable if an amount has been paid to the physician or provider submitting the claim by the patient or subscriber, or on behalf of the patient or subscriber;
- (11) Discharge hour (UB-04, field 16), is applicable if the patient was an inpatient, or was admitted for outpatient observation;
- (12) Condition codes (UB-04, fields 18-28 are applicable if the CMS UB-04 manual contains a condition code appropriate to the patient's condition;
- (13) Occurrence codes and dates (UB-04, fields 31-34), are applicable if the CMS UB-04 manual contains an occurrence code appropriate to the patient's condition;
- (14) Occurrence span code, from and through dates (UB-04, field 36), is applicable if the CMS UB-04 manual contains an occurrence span code appropriate to the patient's condition;
- (15) HCPCS/Rates (UB-04, field 44), is applicable if Revenue Code description used does not adequately describe service provided or if Medicare is a primary or secondary payer;
- (16) Prior payments – payer and patient (UB-04, field 54), is applicable if payments have been made to the physician or provider by the patient or another payer or subscriber, on behalf of the patient or subscriber, or by a primary plan;
- (17) Diagnoses codes other than principle diagnosis code (UB-04, fields 67), is applicable if there are diagnoses other than the principle diagnosis and ICD-9 code is required;
- (18) Ambulance trip report, is applicable for itemizing a covered ambulance service; and
- (19) Anesthesia report, is applicable to report time spent on anesthesia services.

**Additional clean claim elements.** In the event information not specified herein is required to make an accurate determination of proof of loss, the provider will be notified in writing within the applicable regulatory or contractual prompt payment standards. The notice will identify the specific claim or portion of a claim that is being reviewed and the information required. The review is completed within the applicable prompt payment standard following receipt of the information requested from the provider.