Situational clean claim 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) Pay To name, address and ID (UB-04, field 2), required when the Pay To information is different than Billing provider info in field 1;

(12) Medical/ health record number (UB-04, field 3b), not the same as 3a;

(13) Discharge hour (UB-04, field 16), is applicable if the patient was an inpatient, or was admitted for outpatient observation;

(14) 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;

(15) 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;
(16) Occurrence span code, from and through dates (UB-04, field 35-36), is applicable if the CMS UB-04 manual contains an occurrence span code appropriate to the patient's condition;
(17) Non-covered charges (UB-04, field 48), required when applicable;
(18) 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;
(19) Diagnoses codes other than principle diagnosis code (UB-04, fields 67A-Q), is applicable if there are diagnoses other than the principle diagnosis and ICD-10 code is required effective 10/1/15;
(20) Principal procedure code and date (UB-04, field 74), required on inpatient claims when a procedure was performed;
Other procedure codes and dates (UB-04, field 74a-e), required on inpatient claims when additional procedures must be reported;
(21) Ambulance trip report, submitted as an attachment to the claim; and
(22) 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.