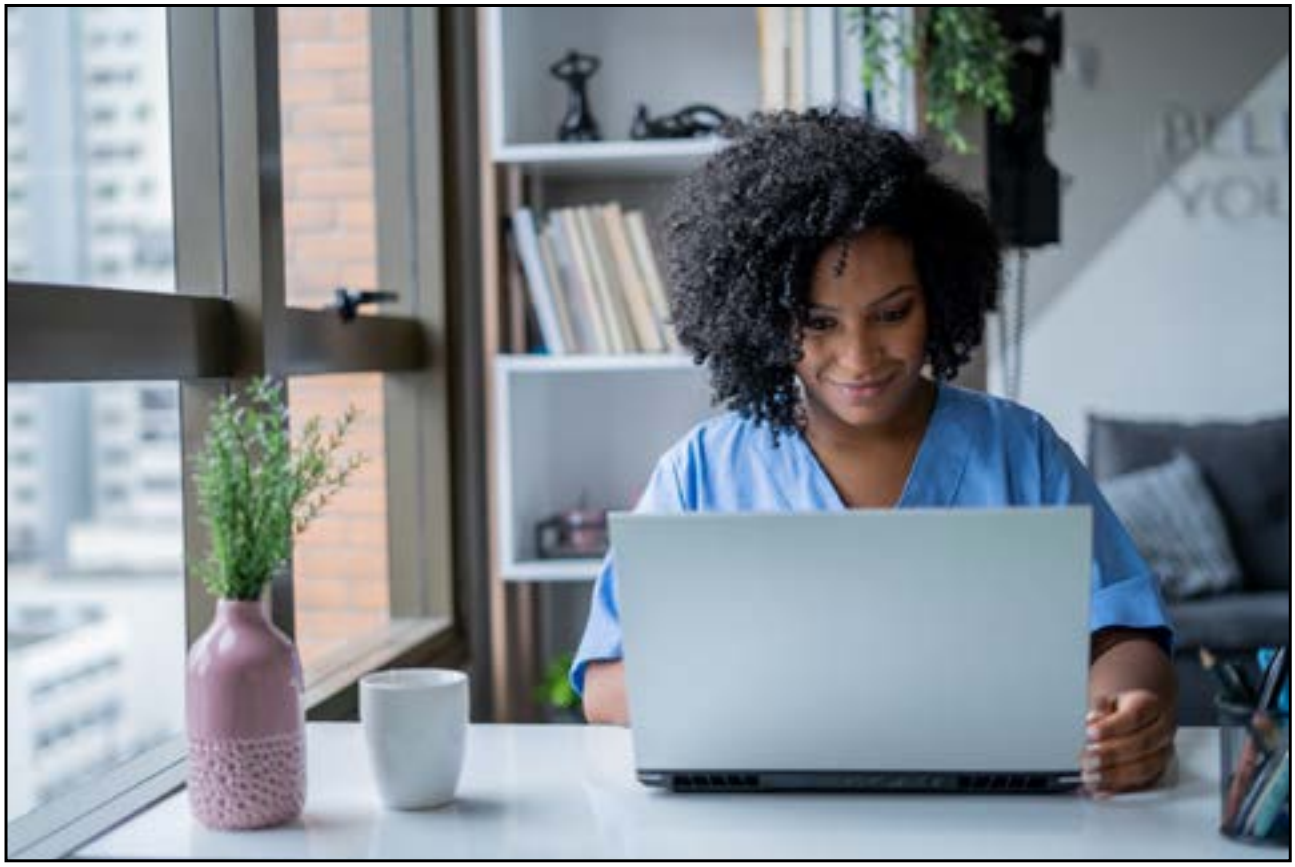
mln Booklet
KNOWLEDGE • RESOURCES • TRAINING

Medicare Billing: CMS-1500 & 837P



What's Changed?

Note: No substantive content updates.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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This booklet offers education for health care administrators, medical coders, billing and claims processing personnel, and other medical administrative staff who submit Medicare professional and supplier claims using the **837P (Professional)** and **Form CMS-1500**.

Note: The term patient refers to a Medicare beneficiary.

What are the Form CMS-1500 & the 837P?

Form CMS-1500

When CMS allows a paper claim, the Form CMS-1500 is the standard claim form to bill Medicare Administrative Contractors (MACs). CMS allows providers to submit a paper claim if they meet the Administrative Simplification Compliance Act (ASCA) exceptions.

Sometimes providers use the CMS-1500 and the 837P to bill certain government and private insurers. We make data elements in the hard copy data set consistent with the uniform electronic billing specifications to the extent that 1 processing system can handle both.

837P

The 837P is the standard format health care professionals and suppliers use to submit health care claims electronically.

Professional providers include:

- Ambulance Services
- Clinical Psychologists
- Clinical Social Workers
- Chiropractors
- Nurse Practitioners
- Occupational Therapists
- Opioid Treatment Programs (OTPs)
- Rural Emergency Hospitals (REHs)
- Physicians, like general practitioners, specialists
- Physician Assistants
- Physical Therapists
- Speech-Language Pathologists

ANSI ASC X12N 837P

The ANSI ASC X12N 837P Version 5010A1 is the current electronic claim version. Find more information on the ASC X12 website.

The National Uniform Claim Committee (NUCC) developed a crosswalk between the ASC X12N 837P and the Form CMS-1500 hard copy claim form. MACs may also include a crosswalk on their websites.

ANSI ASC X12N 837P 5010A1: Key Terms

ANSI: American National Standards Institute

ASC: Accredited Standards Committee

X12N: Insurance section of ASC X12 for the health insurance industry's administrative transactions

837: Standard format for transmitting health care claims electronically

P: Professional version of the 837 electronic format

Version 5010A1: Current version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for health care professionals and suppliers

Electronic Transactions Implementation & Companion Guides

Health care professionals or suppliers billing electronic claims must comply with the ASC X12N implementation guide. The 837P Health Care Claim: Professional Implementation Guide is available from X12 by purchasing an X12 License. Visit the X12 licensing webpage to learn more.

ASC X12N implementation guides are specific technical instructions for carrying out each adopted HIPAA standard and have instructions on content and format requirements for each standard's requirements. ASC X12N writes these documents for all health benefit payers.

Each MAC publishes a CMS-approved Medicare FFS HIPAA 837P Companion Guide (CG). CGs define specific Medicare FFS data content requirements used with, but not in place of, the HIPAA 837P.

Find your MAC's website or review the Medicare Fee-for-Service Companion Guides webpage to locate your MAC's CG.

Implementation and companion guides are technical documents, and you may need help from billing agencies, clearinghouses, or software vendors to interpret and implement the information.

ASETT Tool

Use the Administrative Simplification Enforcement and Testing Tool (ASETT) to check if your claims meet HIPAA standards for EDI compliance. Available through CMS's Identity Management (IDM) System, the Test Transaction Tool checks all transactions for compliance, syntax, and business rules, and validates transactions across various formats, including:

- ASC X12 5010
- NCPDP D.0
- ICD-10 diagnostic and procedure codes
- Unique Identifiers

Submitting Medicare Claims

The Medicare Claims Processing Manual has instructions on how to submit claims:

- Chapter 1 has general billing requirements
- Chapter 12 has claims processing instructions for physicians and non-physician practitioners
- Chapter 24 explains electronic filing requirements and the required Electronic Data Interchange (EDI) form before submitting electronic claims
- Chapter 26 explains what each claim must include

The Medicare Benefit Policy Manual and the Medicare National Coverage Determinations (NCD) Manual include helpful submitting claims coverage information.

Coding

Correct coding is important when submitting valid claims. Use current diagnosis and procedure codes and code to the highest level of specificity. Use the greatest number of digits available to make sure claims are as accurate as possible. The Medicare Claims Processing Manual, Chapter 23, has information on diagnosis coding, procedure coding, and instructions for codes with modifiers.

Diagnosis Coding

Use ICD-10-CM to code diagnostic information. Multiple entities publish ICD-10-CM manuals. The CDC website has access to ICD-10-CM codes electronically, or you can buy hard copy code books from code book publishers.

Procedure Coding

Use HCPCS Level I and II codes to code all claim procedures. Level I CPT-4 codes describe medical procedures and professional services. CPT's a numeric coding system the American Medical Association (AMA) maintains. Get the CPT code book at the AMA Bookstore.

The Medicare Learning Network® has an Evaluation and Management Services Guide that offers helpful information about the HCPCS Level I codes subset.

Place of Service Codes

When submitting claims, it's important to include the appropriate Place of Service (POS) codes. POS codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.

For a full list of POS codes, refer to the Place of Service Code Set webpage or the Medicare Claims Processing Manual, Chapter 26.

HCPCS Level II is a standardized coding system used primarily to name products, supplies, and services not included in Level I CPT codes when used outside a physician's office or injections administered within a physician's office or clinic. To view these codes, review the HCPCS code book or visit the Alpha-Numeric HCPCS webpage.

Submitting Accurate Claims

Health care professionals and suppliers must submit accurate claims. For more information on this, review the Medicare Program Integrity Manual, Chapter 4. For the latest billing information, review the Medicare Claims Processing Manual.

Medicare coverage and payment require that an item or service:

- Meets a benefit category
- Isn't specifically excluded from coverage
- Is reasonable and necessary

Submit all documentation that supports compliance with Medicare coverage and coding requirements when the Medicare Review Contractors ask for it.

Modifiers

Use proper modifiers with procedure codes to submit accurate claims. The AMA's CPT code book includes HCPCS Level I codes and modifiers. The HCPCS code book includes HCPCS Level II codes and related modifiers. Resources about modifiers:

- Proper Use of Modifiers 59, XE, XP, XS, & XU fact sheet explains correct use of these modifiers.
- Physician Bonuses webpage explains whether you must use a modifier to get a Health Professional Shortage Area (HPSA) bonus payment.
- Medicare Claims Processing Manual offers modifier information. For example, Chapter 30 includes information on modifiers for Advance Beneficiary Notices (ABNs).
- Medicare National Correct Coding Initiative Policy Manual, Chapter 1, Section E offers detailed information on using modifiers.

Fraud, Waste, & Abuse

In general, we define **fraud** as making false statements or representations of material facts to get some help or payment for which no entitlement would otherwise exist.

Waste describes practices that, directly or indirectly, result in unnecessary Medicare Program costs, like overusing services. Waste is generally not considered to be criminally negligent but rather the misuse of resources.

Abuse describes practices that directly or indirectly result in unnecessary costs to the Medicare Program. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards of care.

It's a crime to defraud the federal government and its programs. Punishment may include imprisonment, significant fines, or both under some laws, including the False Claims Act, the Anti-Kickback Statute, the Physician Self-Referral Law (commonly referred to as the "Stark Law"), and the Criminal Health Care Fraud Statute.

For more information about Medicare Program integrity functions and how you can help protect Medicare from fraud, waste and abuse, refer to the Medicare Program Integrity Manual, Chapter 4. Learn about fraud and abuse definitions, laws used to fight fraud and abuse, government partnerships fighting fraud and abuse, and where to report suspected fraud and abuse in the Medicare Fraud & Abuse: Prevent, Detect, Report booklet.

The MLN also offers compliance education products to help health care providers and suppliers submit accurate claims.

Electronic Filing Exceptions & Waivers

You must submit Medicare initial claims electronically unless you qualify for a waiver or exception under the Administrative Simplification Compliance Act (ASCA).

ASCA Exceptions

Before submitting a hard copy claim on the CMS-1500, determine if it meets 1 or more ASCA exceptions. Medicare exempts health care professional and supplier billing when you:

- Have fewer than 10 full-time equivalent employees (FTEs) and bill a MAC
- Roster bill, which allows mass immunizers to complete 1 CMS-1500 with the flu or pneumonia shot and attach a roster listing patients who got that shot, rather than submitting separate CMS-1500 claim forms
- Submit paper claims under a Medicare demonstration project
- Submit MSP claims when there's more than 1 primary payer and more than 1 allowed amount, including more than 1 contractual obligation amount, as applicable

If you meet an exception, you don't need to submit a waiver request. Health care professionals or suppliers who submit paper claims exception justification to their MAC are either:

- Notified of approval by mail
- Notified exception wasn't approved, and all their paper claims denied, effective the 91st calendar day after the first letter date asking for documentation

If health care professionals or suppliers don't respond to a request for exception information, CMS will deny their paper claims, effective the 91st calendar day after the first letter date asking for documentation.

You can't appeal these decisions.

Waiver Requests

These Unusual Circumstance Waivers are subject to provider self-assessment and always meet waiver criteria:

- Dental claims
- Electricity, phone or communication disruption expected to last longer than 2 business days
- Large group practice or supplier that submits less than 10 claims a month and not more than 120 claims per year

Unusual Circumstance Waivers require Medicare pre-approval to submit paper claims in these situations:

- Provider alleges HIPAA claim transaction implementation guides don't support electronic submission of all data needed for claim adjudication
- Provider isn't small, but all employees have documented disabilities that prevent them from using personal computers for electronic claim submission
- Any other unusual situation documented by a provider to prove that enforcing electronic claim submission requirements is against equity and good conscience

Find more information about ASCA waivers and exceptions on the Electronic Billing & EDI Transactions webpage.

Find more information on ASCA electronic billing requirements and enforcement reviews in the Medicare Claims Processing Manual, Chapter 24, Sections 90–90.6.

Download a sample Form CMS-1500. We don't accept CMS-1500 copies for claim submission because they may not accurately replicate form colors. The system needs these colors for automated form reading. Visit the U.S. Government Bookstore to order the form, or contact local printing companies or office supply stores to get them.

Time Limits for Filing Claims

Medicare claims must be filed with the correct MAC no later than 1 calendar year after the date of service. In general, the start date for determining the 1 calendar year timely filing period is the date of service or "From" and "Through" date on the claim.

Claims will be rejected if you file them after the deadline. When a claim is denied for timely filing, it's not the same thing as an initial determination. As such, the determination that a claim wasn't filed timely can't be appealed for payment.

There are limited exceptions to the 1 calendar year timely filing deadline. For more information, see sections 70, et al. of the Medicare Claims Processing Manual, Chapter 1.

Where to Submit Claims

For patients enrolled in Medicare Fee-for-Service (FFS), submit claims to the MAC for the state where the services were provided. Each DMEPOS supplier submits claims to the DME MAC for the state where the patient resides. Find your MAC's website.

You can't charge patients for completing or filing a claim. We subject providers to penalties for violations.

For patients enrolled in a Medicare Advantage (MA) plan, submit claims to the patient's MA Plan.

For patients with primary coverage other than Medicare, also known as Medicare Secondary Payer (MSP), you must bill the correct primary insurer first. Find information in the Medicare Secondary Payer booklet, the Medicare Secondary Payer manual and the Medicare Secondary Payer webpage.

Resources

- HIPAA and Administrative Simplification webpage
- Medicare Billing: 837P & Form CMS-1500 web-based training course
- Medicare Part B EDI Helpline document
- OIG Office of Audit Services website
- Skilled Nursing Facility Billing Reference educational tool

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