mln BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

Medicare Billing: CMS-1500 & 837P

What's Changed?

We added COVID-19 shots to roster billing (page 8).

Substantive content changes are in dark red.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

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

What Are the CMS-1500 & 837P?

CMS-1500

CMS-1500 is the standard paper claim form that non-institutional providers or suppliers use to bill Medicare Administrative Contractors (MACs). CMS lets providers submit a paper claim if they meet Administrative Simplification Compliance Act (ASCA) exceptions. The National Uniform Claim Committee (NUCC) is responsible for designing and maintaining the CMS-1500 form.

837P

837P is the standard electronic format that health care professionals and suppliers use to submit health care claims. The **ANSI ASC X12N 837P Version 5010A1** is the current electronic claim version. Find more information at the ASC X12 website.

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

Providers use CMS-1500 and 837P to bill certain government and private insurers. CMS makes data elements in the hard copy data set consistent with the uniform electronic billing specifications so 1 processing system can handle both.

Professional providers include:

- Ambulance services
- Chiropractors
- Clinical psychologists
- Clinical social workers
- Nurse practitioners
- Occupational therapists
- Opioid treatment programs
- Physical therapists
- Physician assistants
- Physicians, like general practitioners and specialists
- Rural emergency hospitals
- Speech-language pathologists

MAC websites may include a crosswalk between the CMS-1500 hard copy claim and ASC X12N 837P.

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.

ASC X12N implementation guides give technical instructions for carrying out each adopted HIPAA transaction, including content and format requirements for each. ASC X12N develops these documents for all health benefit payers.

Each MAC publishes a CMS-approved Medicare Fee-for-Service (FFS) HIPAA 837P Companion Guide that defines specific Medicare FFS data content requirements used with, but not in place of, the HIPAA 837P.

Find your MAC's website or review Medicare Fee-for-Service Companion Guides to find your MAC's companion guide.

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

ASETT

Use the Administrative Simplification Enforcement and Testing Tool (ASETT) to check if your electronic claims meet HIPAA standards for Electronic Data Interchange (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
- National Council for Prescription Drug Program (NCPDP) Version 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.

Key chapters include:

- Chapter 1, general billing requirements
- Chapter 10, section 10, home health billing guidelines
- Chapter 12, claims processing instructions for physicians and non-physician practitioners
- Chapter 24, electronic filing requirements and information on the EDI forms needed before you can submit electronic claims
- Chapter 26, completing and processing form CMS-1500 data set

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

Health care professionals and suppliers must submit accurate claims. For more information, see the Medicare Program Integrity Manual, Chapter 4.

To get Medicare coverage and payment, an item or service must:

- Fall within at least 1 benefit category
- Not be specifically excluded from coverage
- Be reasonable and necessary

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

Coding

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

HIPAA requires the reporting of codes for patient diagnoses and procedures using standard content, formats, and coding for health care transactions.

Health Care Code Sets and CMS Code Sets Overview have information on coding for health care.

Diagnosis Coding

Use ICD-10 Clinical Modification (ICD-10-CM) to code diagnostic information. Several organizations publish hard copy or electronic ICD-10-CM manuals. CDC offers access to ICD-10-CM codes electronically.

Procedure Coding

Use HCPCS to code all procedures (except for those performed in inpatient hospitals). HCPCS is divided into 2 main subsystems, Level I and Level II codes.

HCPCS Level I is known as CPT. These codes and modifiers describe medical procedures and professional services. CPT uses a numeric coding system the American Medical Association (AMA) maintains.

HCPCS Level II is a standardized system of codes and modifiers used primarily to name products, supplies, procedures, and services not included in the CPT codes, like ambulance services and, when used outside a physician's office, DMEPOS. HCPCS Quarterly Update has the quarterly updates to the HCPCS file. CMS maintains this code set, except for the Current Dental Terminology (CDT) codes.

The ICD-10 Procedure Coding System (ICD-10-PCS) is used for procedure coding on inpatient facility Medicare Part A claims.

Modifiers

Use proper modifiers with procedure codes to submit accurate claims.

CPT includes HCPCS Level I codes and modifiers.

The HCPCS code file includes HCPCS Level II codes and related modifiers.

Resources about modifiers include:

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

Place of Service Codes

When submitting claims, it's important to include the appropriate Place of Service (POS) codes. POS codes are 2-digit codes that indicate where a service was provided.

For a full list of POS codes, refer to the:

- Place of Service Code Set webpage
- Medicare Claims Processing Manual, Chapter 26, section 10.5

Coding & Billing Dates of Service

Expenses are considered to have been incurred on the date the patient got the item or service, regardless of when it was paid for or ordered.

View the Medicare Benefit Policy Manual, Chapter 15, section 20 for more information.

Make sure you understand the dates of service to submit when billing for these services:

- Cardiovascular monitoring
- Care plan oversight
- Clinical lab services and stored specimens
- Home health certification and recertification
- Home prothrombin time monitoring
- Maternity benefits
- Physician ESRD services
- Psychiatric testing and evaluations
- Radiology
- Surgical and anatomical pathology
- Surgical services
- Transitional care management

Services that occur over the span of 2 calendar dates start on 1 day and conclude the following day. Unless otherwise noted, use either the date the service started or the following day when the service concluded. You can't submit a claim for the service until it's complete.

If you have questions, find your MAC's website.

Electronic Filing Exceptions & Unusual Circumstance Waivers

Submit initial Medicare claims electronically unless you qualify for a waiver or exception under the ASCA.

ASCA Exceptions

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

- Have fewer than 10 full-time equivalent employees and bill your MAC
- Roster bill, which allows mass immunizers to complete 1 CMS-1500 with the COVID-19, flu, or pneumonia shot and attach a roster listing patients who got that shot, rather than submitting separate CMS-1500 forms
- Submit paper claims under a Medicare demonstration project
- Submit Medicare Secondary Payer (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 that the exception wasn't approved

If health care professionals or suppliers don't respond to a request for exception information, we deny their paper claims, effective 91 calendar days after the date of the first letter asking for documentation. You can't appeal these decisions.

Medicare Secondary Payer

For patients with primary coverage other than Medicare, also known as MSP, bill the correct primary insurer first. The Medicare Secondary Payer (MSP) Manual has directions on MSP policies, procedures, claims, and payments. Find more information in the:

- Medicare Secondary Payer booklet
- Medicare Secondary Payer: Don't Deny Services & Bill Correctly fact sheet
- Medicare Secondary Payer webpage

Waiver Requests

Unusual circumstance waivers are subject to provider self-assessment and must meet waiver criteria. CMS grants unusual circumstance waivers for:

- Dental claims
- Electricity, phone, or communication disruption lasting longer than 2 business days
- Large group practice or supplier that submits fewer 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:

- The provider alleges that HIPAA claim transaction implementation guides don't support electronic submission of data needed for claim adjudication
- The 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

For more information, review the:

- Electronic Billing & EDI Transactions webpage
- Medicare Claims Processing Manual, Chapter 24, sections 90–90.6

Download a sample 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 it.

Find CMS-1500 completion and coding instructions in the Medicare Claims Processing Manual, Chapter 26.

Time Limits for Filing Claims

File Medicare claims with your MAC no later than 1 CY after the date of service. In general, the start date for determining the 1 CY timely filing period is the date of service or From and Through date on the claim.

We deny claims filed after the deadline. When a claim is denied for timely filing, it's not the same thing as an initial determination. You can't appeal a determination that a claim wasn't filed on time.

There are limited exceptions to the 1 CY timely filing deadline. For more information, see Medicare Claims Processing Manual, Chapter 1, section 70.

Where to Submit Claims

Medicare FFS: For patients enrolled in Medicare FFS, submit claims to the MAC for the state where you provided the services. DMEPOS suppliers submit claims to the DME MAC for the state where the patient lives. Find your MAC's website.

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

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

Fraud, Waste & Abuse

Medicare **fraud** includes:

- Submitting claims for certain improperly referred designated health services.
- Knowingly submitting, or causing to be submitted, false claims or misrepresenting facts to get a federal health care payment where no entitlement would otherwise exist.
- Knowingly soliciting, receiving, offering, or paying remuneration to induce or reward referrals for items or services paid for by federal health care programs. Remuneration can be money (for example, discounts, kickbacks, or bribes) or providing items or services for free or for other than fair market value.

Waste describes practices that, directly or indirectly, result in unnecessary Medicare Program costs, like overusing services. Waste isn't generally considered to be criminally negligent but is 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 Medicare Learning Network® also offers compliance education products to help institutional providers submit accurate claims.

Resources

- Evaluation and Management Services
- HIPAA and Administrative Simplification
- Medicare Billing: CMS-1500 & 837P web-based training course
- Medicare Part B EDI Helpline
- OIG Fraud & Abuse Laws
- OIG Office of Audit Services