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FACT SHEET
KNOWLEDGE • RESOURCES • TRAINING

Medicare Billing: 837P & Form CMS-1500

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

What's Changed?

- Added new tool (page 3)
- Added late claims exceptions (page 6)
- Added electronic filing exceptions & waiver requests information
  - ASCA exceptions (page 7)
  - Waiver requests (page 8)
- Booklet reordered (throughout)

You'll find substantive content updates in dark red font.

This booklet offers education for health care administrators, medical coders, billing and claims processing personnel, and other medical administrative staff responsible for submitting Medicare professional and supplier claims using the **837P** or Health Insurance Claim Form (CMS-1500) (referred to as **CMS-1500** throughout).

Together we can advance health equity and help eliminate health disparities for all minority and underserved groups. Find resources and more from the CMS Office of Minority Health:

- Health Equity Technical Assistance Program
- Disparities Impact Statement

Note: The term patient refers to a Medicare beneficiary.

New Tool

An Administrative Simplification Enforcement and Testing Tool (ASETT) is available through CMS's Identity Management (IDM) System. The Test Transaction Tool checks all transactions for compliance, syntax, and business rules. Validate transactions across various formats:

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

Submitting Accurate Claims

Health care professionals and suppliers must submit accurate claims (get information in the Medicare Program Integrity Manual, Chapter 4) and maintain current Medicare billing knowledge (get information in the Medicare Claims Processing Manual).

Medicare coverage and payments require an item or service:

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

Submit all documentation your Medicare Administrative Contractor (MAC) needs to support the patient's medical need when requested.

837P

The 837P (Professional) is the standard format health care professionals and suppliers use to send health care claims electronically.

ANSI ASC X12N 837P

The ANSI ASC X12N 837P (Professional) 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 hard copy claim form (MACs may include a crosswalk on their websites).

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 sending health care claims electronically

P: Professional version of 837 electronic format

Form CMS-1500

We allow physicians, practitioners, and suppliers to submit a 1500 Health Insurance Claim Form under certain situations.

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

Coding

Correct coding's important when submitting valid claims. Use current diagnosis and procedure codes and complete claims to the highest specificity level available (maximum digit number) to ensure the most accurate claims. Medicare Claims Processing Manual, Chapter 23 has information on diagnosis coding, procedure coding, and codes with modifier instructions.

Diagnosis Coding

Use ICD-10-CM to code claims' diagnostic information. 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® (MLN) has an Evaluation and Management Services Guide (HCPCS Level I codes subset).

HCPCS Level II, a standardized coding system used primarily to identify products, supplies, and services not included in 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 Medicare Claims

The Medicare Claims Processing Manual has submitting claims instructions:

- Chapter 1 has health care professionals and suppliers general billing requirements
- Chapter 24 explains electronic filing requirements and the Electronic Data Interchange (EDI) form required before submitting electronic claims
- Chapter 26 explains what each 837P or CMS-1500 claim must include

The Medicare Benefit Policy Manual and Medicare National Coverage Determinations Manual include helpful, submitting claims coverage information.

Modifiers

Use proper modifiers with procedure codes to submit correct 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 & –X{EPSU} fact sheet explains correct use of modifiers 59 and –X{EPSU}
- 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

Where to Submit Claims

For patients enrolled in Medicare Fee-for-Service (FFS), submit service claims to your MAC. 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 insurer first. Find information in the Medicare Secondary Payer booklet and the Medicare Secondary Payer Provisions Web-Based Training (WBT) course.

Timely Filing

Providers must file Medicare claims to their MAC no later than 12 months, or 1 calendar year, after the service date.

We'll deny claims if they arrive after the deadline. When we deny a claim for timely filing, this isn't the same thing as an initial determination. If you don't file the claim timely, you can't appeal it for payment.

For claims submitted by health care professionals and suppliers that spans service dates, we use the line item **From** date to determine the claims filing timeliness service date (this includes durable medical equipment, supplies, and rental items). If a line item **From** date isn't timely but there's a timely **To** date, we split the line item and deny the untimely services.

Late Claims Exceptions

Find information on timely filing exceptions at Medicare Claims Processing Manual, Chapter 1, Section 70.5.

Electronic Transactions Implementation & Companion Guides

Health care professionals or suppliers billing electronic claims must comply with the ASC X12N implementation guide. You can buy the 837P Health Care Claim: Professional Implementation Guide. It has instructions on content and format requirements for each standard's requirements. ASC X12N implementation guides are specific technical instructions for implementing 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).
  - CG defines 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 CG.

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

Electronic Filing Exceptions & Waivers

Providers must submit initial Medicare claims electronically unless they qualify for a waiver or exception under the electronic claims submission Administrative Simplification Compliance Act (ASCA) requirement.

ASCA Exceptions

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

- Have less than 10 Full-Time Equivalent (FTE) employees and bill a MAC
- Roster bill, which allows mass immunizers to complete 1 CMS-1500 with the shot type (flu or pneumococcal) 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 are either:

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

Health care professionals or suppliers who don't respond to a request for exception information get denied paper claims, effective the 91st day after the first letter date requesting documentation.

Health care professionals or suppliers 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 or phone communication disruption
- Large group practice or supplier that submits less than 10 claims per 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 claim transaction implementation guides adopted under HIPAA don't support electronic submission of all data required for claim adjudication
- Provider isn't small, but all those employed have documented disabilities that prevent personal computer use for electronic claim submission
- Any other unusual situation documented by a provider to establish enforcement of 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 health care professionals and suppliers electronic billing requirements and enforcement reviews in 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 requires the colors for automated form reading. We only accept claim forms printed in Flint OCR Red, J6983, (or exact match) ink. Visit the U.S. Government Bookstore to order the form, or contact local printing companies or office supply stores to get them.

Resources

- EDI Helpline
- HIPAA and Administrative Simplification webpage
- Medicare Billing: Form CMS-1500 and the 837 Professional web-based training
- OIG Office of Audit Services (reports about specific coding and billing issues)