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BOOKLET

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Medicare Billing: Form CMS-1450 and the 837 Institutional

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CONTENTS

> **What's Changed?**
> - Updated MSP information in the Medicare Claims Submission section.
> - Where to Submit FFS Claims section was added

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

Introduction

This booklet presents education for health care administrators, medical coders, billing and claims processing personnel, and other medical administrative staff who are responsible for submitting Medicare provider claims for payment using the Form CMS-1450 or 837I.

Note: The term "patient" refers to a Medicare patient.

What Are the 837I and the Form CMS-1450?

837I

The 837I (Institutional) is the standard format used by institutional providers to transmit health care claims electronically. Review the chart below for the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P for more information about this claim format.

Form CMS-1450

The Form CMS-1450, also known as the UB-04, is the standard claim form to bill Medicare Administrative Contractors (MACs) when a paper claim is allowed. The Centers for Medicare & Medicaid Services allows providers to bill using a paper claim when the providers fulfill the Administrative Simplification Compliance Act (ASCA) exception to electronic claims provisions.

In addition to billing Medicare, the 837I and Form CMS-1450 sometimes may be suitable for billing various government and some private insurers. Data elements in the CMS uniform electronic billing specifications are consistent with the hard copy data set to the extent that 1 processing system can handle both.

Institutional providers include hospitals, Skilled Nursing Facilities (SNFs), End Stage Renal Disease (ESRD) providers, Home Health Agencies (HHAs), Hospice Organizations, Outpatient Physical Therapy/Occupational Therapy/Speech Pathology Services, Comprehensive Outpatient Rehabilitation Facilities (CORFs), Community Mental Health Centers (CMHCs), Critical Access Hospitals (CAHs), Federally Qualified Health Centers (FQHCs), Histocompatibility Laboratories, Indian Health Service (IHS) Facilities, Organ Procurement Organizations, Religious Non-Medical Health Care Institutions (RNHCIs), and Rural Health Clinics (RHCs).

ANSI ASC X12N 837I

The ANSI ASC X12N 837I (Institutional) Version 5010A2 is the current electronic claim version. To learn more, visit the ASC X12 website.

- 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
- I = Institutional version of the 837 electronic format
- Version 5010A2 = Current version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for institutional providers

The National Uniform Billing Committee (NUBC) makes its UB-04 manual available through its website. This manual contains the updated specifications for the data elements and codes included on the CMS-1450 and used in the 837I transaction standard. MACs may include a crosswalk between the ASC X12N 837I and the CMS-1450 on their websites.

Implementation and Companion Guides for Electronic Transactions

ASC X12N implementation guides are the specific technical instructions for implementing each of the adopted HIPAA standards and give instructions on the content and format requirements for each of the standards' requirements. The documents are written for use by all health benefit payers, not specifically for Medicare.

You can purchase implementation guides, including the latest adopted version of the electronic claim consolidated guides at the ASC X12 store or from the Washington Publishing Company by contacting them at 425-562-2245 or email admin@wpc-edi.com.

CMS publishes a companion guide to supplement the implementation guide to give further instruction specific to Medicare. The 5010A2 - Part A 837 Companion Guide gives specific 837I electronic claim loop and segment references. MACs also publish their own companion documents, which give more information specific to that contractor's business. Contact your MAC to locate your companion guide. Implementation guides and companion guides are technical documents, and providers may require help from software vendors or clearinghouses to interpret and implement the information within the guides.

Medicare Claims Submissions

Go to the IOMs webpage for the Medicare Claims Processing Manual (Internet-Only Manual Publication [IOM Pub.] 100-04). This publication includes instructions on claims submission. Chapter 1 includes general billing requirements for various institutional providers. Other chapters offer claims submission information specific

to an institutional provider type. Once in IOM Pub. 100-04, look for a chapter(s) applicable to your institution and then search within the chapter for claims submission guidelines. For example, Chapter 10 – Home Health Agency Billing contains home health billing guidelines.

Visit Chapter 24 to learn more about electronic filing requirements, including the Electronic Data Interchange (EDI) enrollment form that's required before submitting Electronic Claims or other EDI transactions to Medicare. Refer to Chapter 25 to learn what each claim must include in the 837I or in each field of the CMS-1450.
The Medicare Benefit Policy Manual, (IOM Pub. 100-02), and the Medicare National Coverage Determinations (NCD) Manual, (IOM Pub. 100-03), both include coverage information helpful in claims submission. Search for coverage guidance once within a chapter.

Refer to the MSP Manual found in IOM Pub. 100-05, which provides direction on MSP policies, procedures, MSP claims and MSP payments.

Coding

Correct coding is key to submitting valid claims. Use current valid diagnosis and procedure codes and code to the highest level of specificity (maximum number of digits) available to ensure claims are as accurate as possible. The Medicare Claims Processing Manual, Chapter 23 – Fee Schedule Administration and Coding Requirements includes information on diagnosis coding and procedure coding, as well as instructions for codes with modifiers.

Diagnosis Coding
To code diagnostic information on claims, use the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Multiple entities publish ICD-10-CM manuals and you can purchase the full ICD- 10-CM from the AMA Bookstore.

Procedure Coding
Use Healthcare Common Procedure Coding System (HCPCS) Level I and II codes to indicate procedures on all claims, except for inpatient hospitals. Use ICD-10-PCS codes for procedure coding on inpatient hospital Part A claims.

For all other uses, Level I Current Procedural Terminology (CPT-4) codes describe medical procedures and professional services. CPT is a numeric coding system and the AMA maintains it. Go to the AMA Bookstore for the CPT codebook.

The Medicare Learning Network® offers the Evaluation and Management (E/M) Services guide. It has information about E/M codes, which are a subset of HCPCS Level I codes.

Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Because Medicare and other insurers cover a variety of services, supplies, and equipment that aren't identified by CPT codes, the AMA and CMS established codes for submitting claims for these items. To view these codes, review the HCPCS codebook or visit the Alpha-Numeric HCPCS webpage.

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National Uniform Billing Committee (NUBC) Codes

The 837I and CMS-1450 also require the use of codes maintained by the NUBC including:

- Condition codes
- Occurrence codes
- Occurrence Span codes
- Value codes
- Revenue codes
- Type of Bill
- Discharge status
- Point of Origin
- Type of Visit

More information is available to subscribers of the NUBC Official UB-04 Data Specifications Manual. To subscribe go to the NUBC website.

Submitting Accurate Claims

Providers play a vital role in protecting the integrity of the Medicare Program by submitting accurate claims, maintaining current knowledge of Medicare billing policies, and ensuring all documentation the MAC requires to support the medical need for the service rendered is submitted when requested.

> **Modifiers**
>
> Proper use of modifiers with procedure codes is essential to submitting correct claims.
>
> The AMA's CPT codebook includes HCPCS Level I codes and modifiers, while the HCPCS codebook includes HCPCS Level II codes and related modifiers. Resources about modifiers on the CMS website include:
>
> - The Modifier 59 article explains the correct use of -59 as a distinct procedural service.
> - Chapters of the Medicare Claims Processing Manual (IOM Pub. 100-04) also offer modifier information. For example, Chapter 30 includes information related to modifiers for Advance Beneficiary Notices (ABNs).

In addition to correct claims completion, Medicare coverage and payment requires that an item or service:

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

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

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program.

It's a crime to defraud the Federal government and its programs. Punishment may include imprisonment,

significant fines, or both under a number of laws, including the False Claims Act, the Anti-Kickback Statute, the Physician Self-Referral Law (Stark Law), and the Criminal Health Care Fraud Statute.

For more information about Medicare Program integrity functions and how institutional providers can help protect Medicare from fraud and abuse, refer to the Medicare Program Integrity Manual (IOM Pub. 100- 08, Chapter 4). The MLN also offers the Medicare Fraud & Abuse: Prevent, Detect, and Report booklet. Learn about the fraud and abuse definitions, laws used to fight fraud and abuse, government partnerships engaged in fighting fraud and abuse, and where to report suspected fraud and abuse.

The MLN also offers a number of compliance education products to help institutional providers submit accurate claims.

When Does Medicare Accept a Form CMS-1450?

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

Before submitting a hard copy claim, providers should self-assess to determine if they meet 1 or more of the ASCA exceptions. For example, institutional providers that have fewer than 25 Full-Time Equivalent (FTE) employees are considered small. They might qualify to be exempt from Medicare electronic billing requirements when submitting a bill to a MAC. If an institutional provider meets an exception, it doesn't need to submit a waiver request.

CMS may also waive the ASCA electronic billing requirement in certain other situations for some or all claims, such as if disability of all members of an institutional provider's staff prevents use of a computer for electronic submission of claims. Institutional providers must get Medicare pre-approval to submit paper claims in these situations by submitting a waiver request to their MAC.

To learn more about the ASCA waivers and exceptions, visit the Electronic Billing & EDI Transactions webpage and go to the left menu to select 1 of the ASCA options. Refer to Chapter 24, Sections 90-90.6, of the Medicare Claims Processing Manual (IOM Pub. 100-04) for more information on ASCA electronic billing requirements and enforcement reviews of institutional providers.

Download a sample of the form by visiting the CMS Forms List webpage. In the Filter On box, enter 1450. Downloaded copies of the CMS-1450 aren't usable for submission of claims, since they may not accurately replicate colors included in the form. These colors enable automated reading of information on the form. Visit the Institutional Paper Claim Form (CMS-1450) webpage for information on getting the CMS-1450.

Timely Filing

Providers and suppliers must file Medicare claims to the proper MAC no later than 1 calendar year after the date of service.

Medicare will deny claims if they arrive after the deadline date. The determination that a claim wasn't filed timely isn't subject to appeal.

In general, the start date for determining the 1 calendar year timely filing period is the date of service or From date on the claim. For claims that include span dates of service (a From and Through date span on the claim), we use the Through date on the claim to determine the date of service for claims filing timeliness.

Medicare regulations allow exceptions to the 1 calendar year time limit for filing claims. To review these exceptions, refer to the Medicare Claims Processing Manual (IOM Pub. 100-04, Chapter 1).

Where to Submit FFS Claims

For patients enrolled in Original Fee-For-Service (FFS) Medicare, health care professionals or suppliers may submit claims for services to the appropriate MAC. Contact your MAC if you have questions. Medicare patients can't be charged for completing or filing a claim. Providers may be subject to penalty for violations.

For patients enrolled in a Medicare Advantage (MA) Plan, health care professionals or suppliers should submit claims to the patient's MA Plan. CMS has a list of MA Claims Processing Contacts.

Medicare Secondary Payer (MSP)
MSP provisions apply to situations when Medicare isn't the patient's primary health insurance coverage. MSP provisions ensure that Medicare doesn't pay for services and items that certain other health insurance or coverage is primarily responsible for paying. For more information, refer to Medicare Secondary Payer booklet and the Medicare Secondary Payer Provisions WBT. The Medicare Secondary Payer webpage offers information on MSP laws and the various methods CMS gathers data on other insurance potentially primary to Medicare.

Resources

- E/M Services Guide
- MAC Website List
- Medicare Claims Processing Manual Chapter 1 – General Billing Requirements
- Medicare Claims Processing Manual Chapter 10 – Home Health Agency Billing
- Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections
- NCD Manual (IOM Pub. 100-03)
- MSP Manual (IOM Pub. 100-05)

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