mln Fact Sheet
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Medicare Billing: 837I & Form CMS-1450

What's Changed?

Note: No substantive content updates.

This fact sheet offers education for health care administrators, medical coders, billing and claims processing personnel, and other medical administrative staff who submit Medicare provider claims for payment using the **837I** and **Form CMS-1450**.

Note: The term patient refers to a Medicare beneficiary.

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

837I

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

Form CMS-1450

When CMS allows a paper claim, the Form CMS-1450, also known as the UB-04, it's the standard claim form to bill Medicare Administrative Contractors (MACs). We allow providers to submit a paper claim if they meet the Administrative Simplification Compliance Act (ASCA) exceptions.

Sometimes providers use the 837I and CMS-1450 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 both.

Institutional providers include:

- Community Mental Health Centers (CMHCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals (CAHs)
- ESRD providers
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Home Health Agencies (HHAs)
- Hospice organizations
- Hospitals
- Indian Health Service (IHS) Facilities
- Organ Procurement Organizations
- Outpatient Physical Therapy (OPT)/ Occupational Therapy (OT)/Speech-Language Pathology (SLP) Services
- Religious non-medical health care institutions (RNHCIs)
- Rural health clinics (RHCs)
- Skilled nursing facilities (SNFs)

ANSI ASC X12N 837I

The ANSI ASC X12N 837I (Institutional) Version 5010A2 is the current electronic claim version. Find more information on the ASC X12.

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

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's (NUBC) offers their UB-04 manual through its website. This manual has 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.

Electronic Transactions Implementation & Companion Guides

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 X12 writes these documents for all health benefit payers.

Providers billing electronic claims must follow the ASC X12N implementation guides. The 837I Health Care Claim: Institutional Implementation Guide is available from X12 by purchasing an X12 License. You can read more about X12 licensing.

Each MAC publishes a CMS-approved companion guide to supplement the implementation guide that offers further Medicare instructions. The 5010A2 - Part A 837 Companion Guide offers specific 837I electronic claim loop and segment references. Find your MAC's website or review the Medicare Fee-for-Service Companion Guides webpage to locate your MAC's Companion Guide.

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.

Submitting Medicare Claims

The Medicare Claims Processing Manual has submitting claims instructions:

- Chapter 1 includes general billing requirements
- Chapter 24 explains electronic filing requirements and the required Electronic Data Interchange (EDI) form before sending electronic claims
- Chapter 25 explains what each claim must include

Other chapters apply to specific institutional provider types. For example, Chapter 10 – Home Health Agency Billing has home health billing guidelines.

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

Refer to the Medicare Secondary Payer Manual (MSP) for direction on MSP policies, procedures, claims, and payments.

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, includes information on diagnosis coding, procedure coding, and instructions for codes with modifiers.

Diagnosis Coding

Use ICD-10-CM to code claims' 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 claims procedures, except for inpatient hospitals. Use ICD-10-PCS codes for procedure coding on inpatient hospital Part A claims.

Level I CPT-4 codes describe medical procedures and professional services. CPT's a numeric coding system the AMA maintains. Get the CPT code book at the AMA Store.

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

HCPCS Level II is a standardized coding system used primarily to name products, supplies, and services not included in the CPT codes like ambulance services and DMEPOS. To view these codes, review the HCPCS codebook or visit the Alpha-Numeric HCPCS webpage.

National Uniform Billing Committee (NUBC) Codes

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

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

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 can protect the integrity of the Medicare Program by:

- Keeping current on knowledge of Medicare billing policies
- Submitting accurate claims
- Submitting all MAC-required documentation to support the medical need for services

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, and XU fact sheet explains the correct use of modifiers 59 and-X{EPSU}.
- Medicare Claims Processing Manual offers modifier information. For example, Chapter 30 includes information on modifiers for Advance Beneficiary Notices (ABNs).

Medicare coverage and payment require that an item or service:

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

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.

Abuse describes practices that 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 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 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 institutional providers submit accurate claims.

When Does Medicare Accept a Form CMS-1450?

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

Before submitting a hard copy claim on the CMS-1450, decide if it meets 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 billing a MAC. If an institutional provider meets an exception, it doesn't need to submit a waiver request.

CMS may also exempt providers in certain situations for some or all claims, such as if disability of all members of your staff prevents using a computer for electronic submission of claims. You must get pre-approval to submit paper claims in these situations by submitting a waiver request to your MAC.

Find more information on ASCA waivers and exceptions on the Electronic Billing & EDI Transactions webpage. Refer to Sections 90-90.6 of the Medicare Claims Processing Manual, Chapter 24, for more information on ASCA electronic billing requirements and enforcement reviews.

CMS doesn't supply the form to providers for claim submission. Don't download a copy of the form to submit claims because your copy may not correctly replicate form colors. The system needs the 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" date on the claim.

Claims will be denied if they are filed after the deadline. When a claim is denied for timely filing, it is not the same thing as an initial determination. As such, the determination that a claim was not filed timely cannot 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 on the CMS website.

Where to Submit Claims

For patients enrolled in Original Fee-for-Service (FFS) Medicare, submit service claims to your MAC. Find your MAC's website if you have questions. 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, unless otherwise directed. Visit the MA Claims Processing Contacts webpage for a list of those contacts.

Medicare Secondary Payer (MSP)

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, the Medicare Secondary Payer Manual, and the Medicare Secondary Payer webpage.

Resources

- CMS-1450 form
- HIPAA and Administrative Simplification webpage
- Medicare Billing 837I & Form CMS-1450 web-based training course
- Medicare EDI Helplines document