



# Proper Part B Claim Submissions

7/23/2024

**Closed Captioning**: Auto-generated closed captioning is enabled in this course and is at best 70-90% accurate. Words prone to error include specialized terminology, proper names and acronyms.





## Today's Presenters

Provider Outreach and **Education Consultants** 

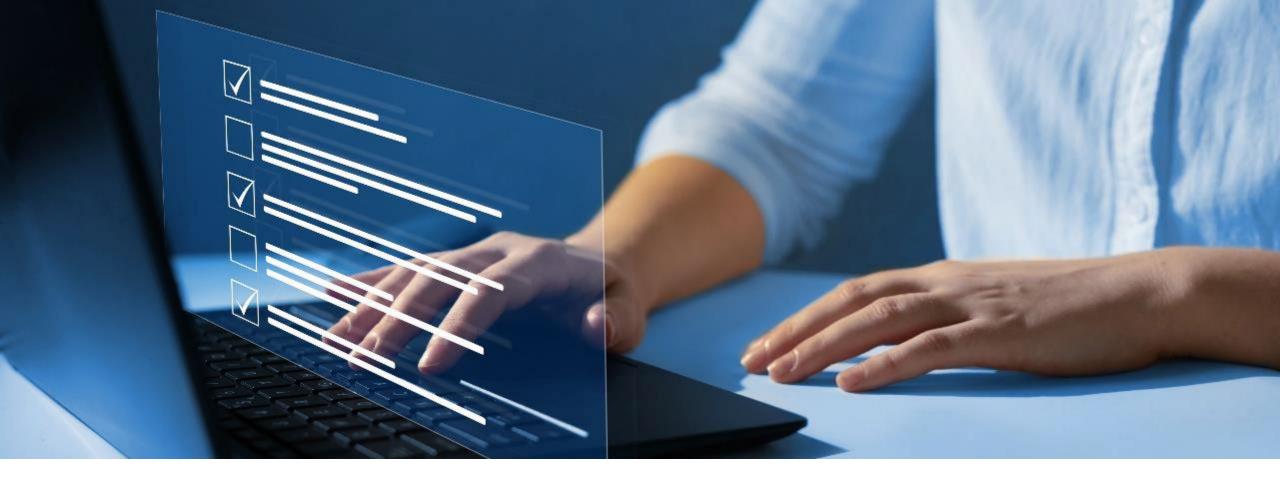
- Arlene Dunphy, CPC
- Carleen Parker









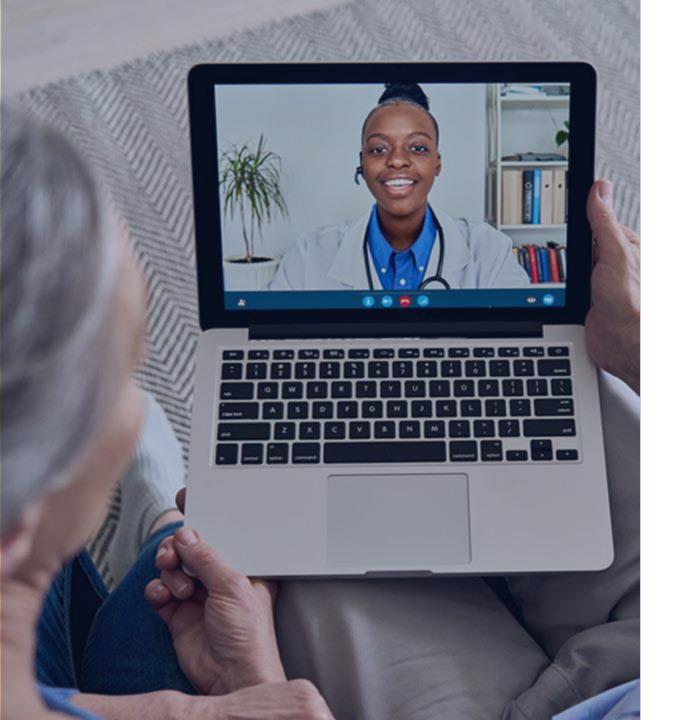


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## Objective

After completion attendees will be able to

- Familiarize yourself with claim submission requirements
- Avoid unnecessary claim denials and claim rejections
- Understand the benefits of electronic submissions







## Agenda

- Claim Form Requirements
- Time Limits for Filing
   Medicare Claims
- <u>Claim Form Overview</u>
- Resources, References and Tools







# Claim Form Requirements

## Claim Submission Requirements

#### Paper

- Original CMS-1500 Claim Form
- Use an ink jet or laser printer
- Use Courier New font for computer-generated claims
- Ensure no lines from the printer cartridge are anywhere on the claim
- Use Pica 10 or 12-point typeface for claims typed
- Use upper case letters for all claim data
- Data should not be touching box edges or running outside of numbered boxes
- Cannot contain more than six service lines per claim
- No stickers, bold, italics, or underlining

#### Electronic or paper

- Do not use narrative or handwritten descriptions
  - Procedure, modifier or diagnosis
- Do not use special characters
  - hyphens, periods, parentheses, dollar signs or ditto marks







## **ASCA Regulations**

- Requires most providers to submit all claims electronically
- ASCA regulations exceptions include
  - Providers submitting less than ten claims per month
  - Physician/practitioner/supplier with less than ten full-time equivalent employees
  - Medicare tertiary (third) payer claims
  - Certain mass immunizers
- ASCA Requirements for Paper Claim Submissions





# Time Limits for Filing Medicare Claims

## Claim Filing Time Limits

- Limit is one calendar year from date of service
  - Claims not submitted timely are provider-liable
    - Beneficiary cannot be charged
- Exceptions
  - MLN Matters® <u>MM7270 Revised: Changes to the Time Limits for Filing Medicare Fee-For-Service Claims</u>
  - Administrative error
  - Retroactive Medicare entitlement, including when State Medicaid agencies involved
  - Retroactive disenrollment from Medicare Advantage Plan or PACE Provider Organization

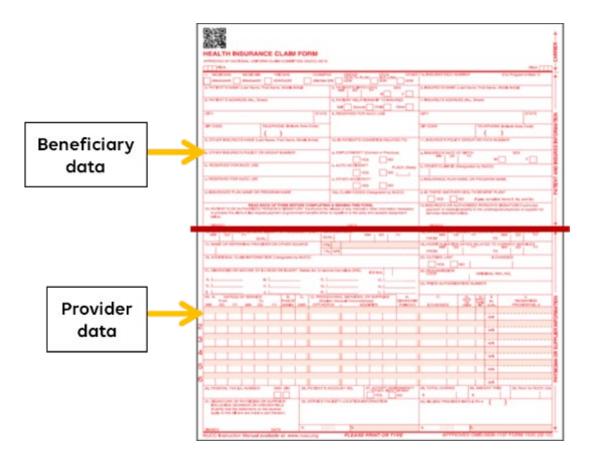






# Claim Form Overview

# CMS-1500 Claim Form (02/12)



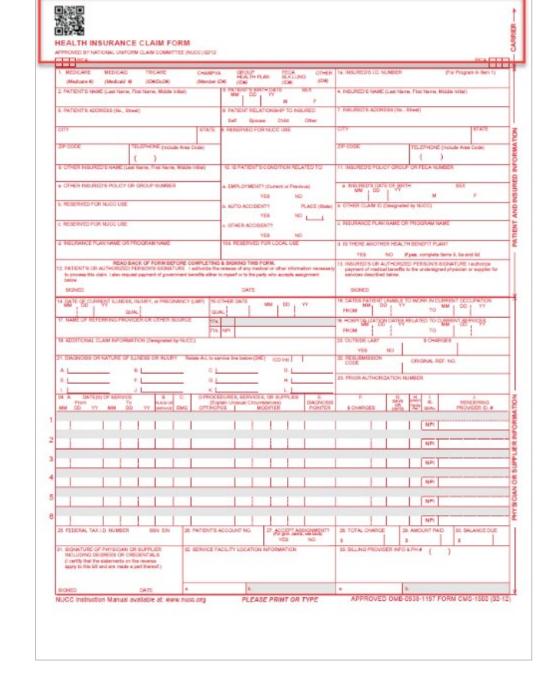






## **NUCC Approved OMB**

- Office of Management and Budget
  - OMB-0938-1197 1500
- 1500 Health Insurance Claim Form
  - Header
- QR code







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 When submitting your claims to Medicare, the Medicare box shall be checked; otherwise, your claim(s) will be rejected and returned

П	Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
П				SBR09	Claim editing indicator code	Must = MB for Medicare Part B
П	1	Type of Health Insurance	20008	SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary
П				SBR02	Individual Relationship Code	Individual relationship code (18 = Self)





#### Line Item 1a

- Enter the patient's Medicare MBI as it appears on patient's red, white and blue Medicare card for all Medicare claim submissions (primary or secondary)
  - Term "Medicare number" and "Medicare ID"
  - MBI is 11 characters in length and made up only of numbers and uppercase letters (no special characters)
  - Lowercase letters will be converted to uppercase letters
  - MBIs are assigned by SSA

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements	]
1a*	Patient's Medicare Beneficiary ID Number (MBI)	2010BA	NM109	Subscriber Primary Identifier	Patient's Medicare Beneficiary ID Number (MBI)	





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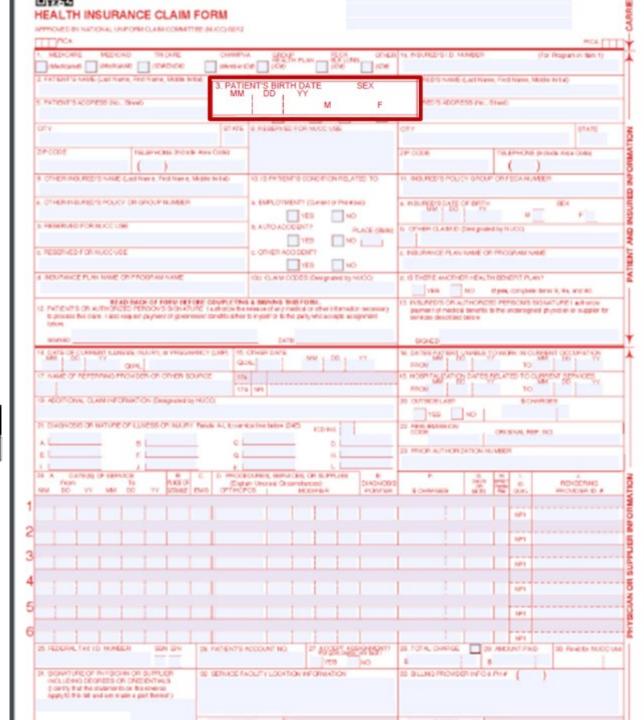
 Patient's last name, first name and middle initial list exactly as it appears on the patient's red, white and blue Medicare card

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		004004	NM103	Last Name	
2	Patient's Name	2010BA	NM104	First Name	Enter the patient's name as shown on their Medicare card
-	2 Patient's Name	2010CA	NM105	Middle initial	Enter the patient's name as shown on their Medicare card
		20	2010CA	NM107	Suffix (e.g., Jr. Sr.)



 Patient's eight-digit date of birth (MMDDCCYY) and check the appropriate box for patient's sex

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
3	Patient's Birth Date and gender	2010BA	DMG02 DMG03	Birth Date Gender	Enter the patient's birth date. Must be formatted as CCYYMMDD. Date qualifier (DMG01) = D8







	HEALTH INSURANCE CLAIM FORM		
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- Name of the insured, if there is insurance primary to Medicare, either through the patient or spouse's employment or any other source
- Enter the word, "same," when insured is same as patient
- When Medicare is secondary payer (MSP), items 4, 6, 7 and 11 are required items

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Insured's name (When		NM103	Other insured last name	Enter the insured's name. Required if any other payers are
4"	primary to Medicare, items 4, 6, 7, and 11	2330A	NM104	Other insured first name	known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information
	are required items.)		NM105	Other insured middle name	reported in the 2010BA Loop does not repeat in the 2330A Loop.





- Patient's street address on first line, city, state on second line and ZIP code and phone number on third line
- For home visits rendered in state other than patients home address, enter in Item 5 the patient's mailing address and line item 32, enter complete address, including ZIP code, where the service was actually rendered

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
			N301	Subscriber address line 1	
1 1	Defects address and		N302	Subscriber address line 2	
5	Patient's address and telephone number	2010BA	N401	Subscriber city name	Enter the patient's mailing address
1 1	rerepriorie number		N402	Subscriber state	
			N403	Subscriber ZIP code	





EALTH INSURANCE CLAIM FORM	
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#### HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNPOPM CLAM COMMITTEE MAJOR 08/12 Medicand Philosoph / / / / / / / / 2 PATERITY SAME CAST Name, First Name, Under System Self Contitions Fed Spec Make byte. 5. PATIENT'S ACCOMESS DAY, SHARD COSTSS De Steel STATE SUPERSENSE FOR MUCCUSE SPCCOS TSUAPPROPRIES INCHES RIVER CORD 15, 8794 CNS (Include Avea Code) 9. CTHER INDURED'S NAME Cast Name, First Name, Middle Initial 4. OTHER INSURED'S POLICY OR GROUP ILLMEEN A EMPLOYMENTY (Current or Province) D. PROBRUGO FOR MUCC LIMI B. AUTO ACCOUNT? D. COVER CLASS Of the graded by B LCCC e, regarded from NUCCUSE CONTRACODERES INSURANCE PLAN NAME OF PROSPAN NAME 100 4. NEUTANCE PLAN NAME OF PROGRAM NAME OCULANODES Despreyeds NOO I. IS THERE ANOTHER HEW, THREEPIT PLANT 1906 Byon, companie durin 9, 94, sric 90 BEAD BACK OF FORM REFORE COMPLETING A BENANCE BUTCHER. 2 PATIENTS OF AUTHORIZED PERSONS SIGNATURE: Laufuture financiate of any medical or other information receiving I PASLIFIED S OF ALTHORIZED PERSONS SYSTATURE I MELVION payment of needed benefits to the undersigned physician or supplier for to process this play. I also keep an payment of government brieffs after to injust to the party-who accepts as ognined. CHILD 7. NAME OF REFERENCE PROVIDER OF OTHER SOURCE 179 191 FROM 9 ADDITIONAL CLANSINFORMATION Seeguated to 19200 III CRITICIPALARI YES NO COSE COSE CPE SOUN, FEF. NO. B. PRIOR AUTHOR ZATION NUMBER CHONOR **PICHOCRINO** CYTH GE. SERVICE FACILITY LOCATION INFORMATION INCLUDEND DEOPRES OF CREDENTINGS 5 cartly that the stutements or this revenue opply to the tall and one waste a part flower? )

#### Line Item 6

• Complete this line item only when Items 4, 7 and 11 are completed

No.	Claim Description	Loop	Field	Data Element Description	Requirements
6*	Patients relationship to insured if (Complete this litem only when litems 4, 7, and 11 are completed )	2320	SBR02	Required when MSP is involved 01 Spouse 18 Self 19 Child 20 Employee 21 Unknown 39 Organ Donor 40 Cadaver Donor 53 Life Partner G8 Other Relationship	



- Insured's address and telephone number when Medicare is secondary payer
- Line 7 completed when Items
  4, 6 and 11 are completed
- Leave blank when Medicare is primary

No.	Claim Description	Loop	Field	Data Element Description	Requirements
			N301	Other subscriber address line 1	Enter the mailing address of the insured. Required if other
	Insured's address and telephone number		N302	Other subscriber address line 2	payers are known to potentially be involved in paying this claim
7*	(Complete this MSP	2330A	N401	Other subscriber city name	and the information is available. If the insured is the patient this
	claims)		N402	Other subscriber state code	would be blank and information reported in the 2010BA Loop
	ciaims)	Clairisy	N403	Other subscriber ZIP code	does not repeat in the 2330A Loop.





ALTH INSURANCE CLAIM FORM			
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- Reserved for future NUCC use
- Not mapped electronically





## Line Items 9, 9a-9d

- Medigap or supplemental data is appended when claims are not automatically crossed over to medigap or supplemental insurer
- If same as line Item 2, list same
- If different from line Item 2 complete, name of insured
- Policy and/or group number preceded by Medigap or MGAP or MG or payer ID
- Medicare Coordination of Benefits Agreement





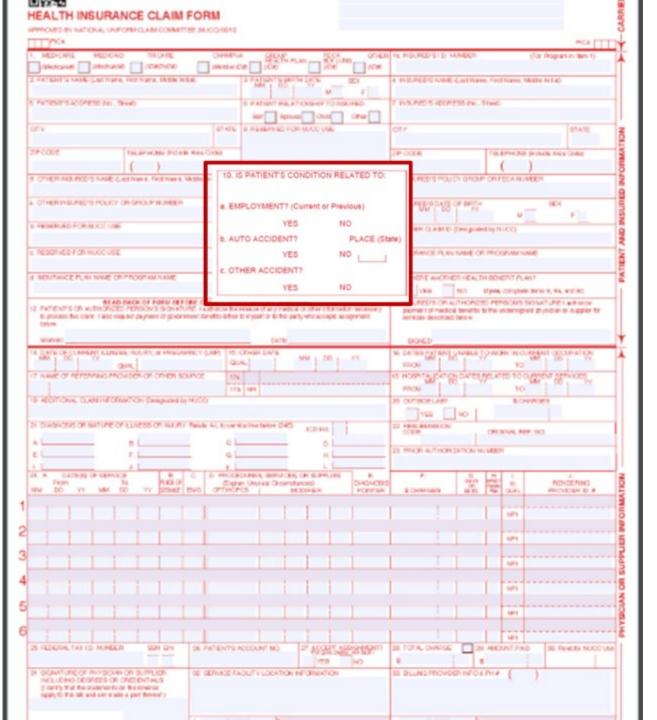
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## EMC Equivalent Lines 9, 9a-9d

- Medigap or supplemental data is appended when claims are not automatically crossed over to medigap or supplemental insurer
- Name of insured for Medigap plan and ID
- Insured group and plan number
- Enter the city, state and ZIP code of the insurer

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Other insured's		MM103	Other insured last name	
9*	Name (Last, First,	2330A	MM104	Other insured first name	Name of insured for Medigap plan
	Middle Initial)		MM105	Other insured middle name	
		2030A	NM108	Identification Code Qualifier (MI Moniber Identification Number)	Medigap policy ID
İ	Other insured's policy		MM109	Other insured identifier	Medigap
Sw*	or group number (Medigap only)	2320	58801	Payer responsibility	P Primary 5 Secondary T Tertary
			28R03	Insured group or policy number	Enter the insured's group or plan number
96*	Other insured's date of birth and sex				
	Employer's name or		N401	Other payor city name	Enter the city, state and ZIP code of the insurer. Required if any
560	school name (Medigap	23308	14402	Other payer state code	other payers are known to potentially be involved in paying this claim.
	Address)		14403	Other payer ZIP code	
96"	ineurance plan name or program name	20305	MM108	Other payer identification Code Qualifier	Medigap plan only
			NM109	Payer last or organization name	
			NM103	Insured's group/policy no.	





# Line Items 10a, 10b and 10c

- Employment, auto liability, or other accident involvement
- If checked "YES," identify primary insurance and submit to the primary and enter the two-letter state postal code for auto liability

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements		
	Is patient's condition related to employment?		CLM11- 1	Employment related indicator (EM)	Enter the name of the Insured's other insurance		
10a,	Auto Accident?	2300			CLM11- 1	Auto accident indicator (AA)	
b, c	Place (State)		CLM11- 4	Auto accident state	Required if Related cause code (CLM11-1,-2) = Auto Accident (AA) to identify the state in which the automobile accident occurred.		
	Other Accident		CLM11- 1	Other accident indicator (OA)	Required if Date of Accident (DTP01 = 439) is used and the service is employment related or the result of an accident.		





### Line Item 10d

- Medicaid crossovers are automatic via eligibility filebased crossover process
- Medicaid number preceded by MCD, when eligibility files are not updated with State Medicaid crossovers
- Not mapped electronically



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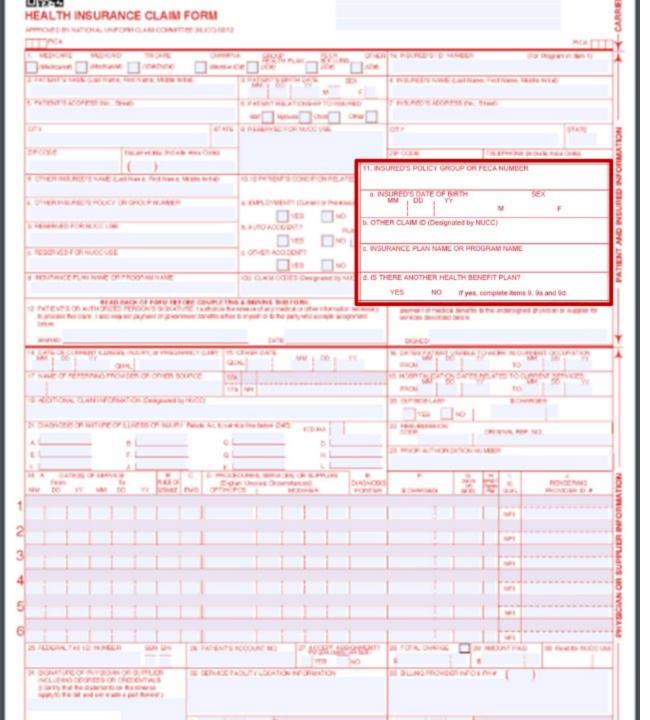
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## Line Items 11, 11a-11d

- If Medicare primary, enter word "NONE" proceed to line Item 12
- If Medicare is secondary (MSP)
  - Insured's policy or group number and proceed to line items 11a through 11c
    - 11a-insured eight-digit DOB and sex code
    - 11b-leave blank
    - 11c–MSP plan name
    - 11d–Not required





# EMC Equivalent Line 11, 11a-11c

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		2320 or 2000B	SBR01	Payer responsibility P = Primary S = Secondary T = Tertiary *Note: If Medicare is Primary, use letter "P" and skip to item 12.	
		2320	SBR03	Insured Group or Policy Number	
		2330A	NM108	Identification Code Qualifier (MI Member Identification Number)	
		0.20000	NM109	Insured's identifier	If there is an insurance primary to Medicare, enter the Insured's policy or group number. Required if other payers are known to potentially be involved in paying this claim.
	Insured policy group			Insurance Type Code	
11*		2000B or 2320 SBR05	SBR05	Indicator's must equal one of the following values: 12, 13, 14, 15, 16, 41, 42, 43 or 47 if 2000B SBR01 = "T" or "S"	
**	or FECA number		CLM01	Claim submitter's identifier	
		2300	CLM02	Monetary amount	
		2320	AMT01	Amount qualifier code = D	
			AMT02	Monetary amount (Primary Paid Claim Level)	
			CAS01	Claim adjustment reason code (CO, PR. OA)	
		2320 or 2430	CAS02	Claim adjustment reason codes	
		2430	CAS03	AS03 Adjustment amount	
			CAS04	Adjustment quantity	
		2330B or	DTP01	Primary insurance adjudication date	
		2430	DTP02	Date time period qualifier	
			DTP03	Date paid	

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		2300 or 2400	CN102	OTAF amount	
			SVD01	Identification code	
			SVD02	Primary payer paid amount (line level)	
			SVD03	Medical procedure identifier	
		2430	SVD03-	Service ID qualifier	
			SVD03- 2	Service ID	
			SVD05	Quantity	
			NM101	Entity identifier code	
			NM102	Entity type code	
		2330B	NM103	Last name or organization	
			NM108	Identification code qualifier	_
	January district of high		NM109	Identification code	
11a*	Insured date of birth and sex-				
11b*	Employer's name or school				
		2320	SBR04	Other Insured Group Name	Enter the complete insurance plan or program name
110	Insurance plan name or program name	23308	NM103	Other payer organization name	Enter the complete insurance plan name
	- programmano	23308	NM109	Other payer primary identifier	Enter the payer ID of the other insurer

Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P





- Signature and date
  - Informed consent to release medical information for conditions or diagnoses regulated by Federal Statutes
  - Statement permitting release of medical billing data related to claim

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Patient's or authorized person's signature (Release of Information)	2300	CLM09	Release of information code	This item authorized release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service when assignment is accepted on the claim.
12		2320	0106	Release of information code	I-Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes. Required when the provider has not collected a signature and state or federal laws do not require a signature to be collected. Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim.





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- Signature and date
  - This item authorizes payment of medigap medical benefits to physician

Item No.	Claim Description		Field Data Element Description		Requirements
42	Insured's or	2300	CLM09	Benefits Assignments Certification Indicator	This item authorizes payment of medical benefits to the physician.
13	Authorized Person's Signature	2320	Q103	Assignment of Benefits Indicator	N No; W Not applicable. Use code "W" when the patient refuses to assign benefits; Y Yes





- Six-digit or eight-digit date of current illness, injury, or pregnancy (LMP)
- Do not enter qualifier (QUAL) in item 14

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		2300	DTP03 (439)	Accident Date	Required if Related Cause code (CLM11-1, -2 or -3) = Auto Accident (AA) or Other (OA). Enter the date of current illness or injury.
14	Date if current illness.	2300	DTP03 (431)	Onset of current illness or injury date	Required for the initial medical service or visit performed in response to a medical emergency when the date is available and is different than the date of service
14	injury, pregnancy	2300	DTP03 (454)	Initial treatment date	Required on all claims involving spinal manipulation.
		2400**	DTP03 (454)	Initial Treatment Date	Required when the Initial Treatment Date is known to impact adjudication for claims involving spinal manipulation, physical therapy, occupational therapy, or speech language pathology and when different from what is reported at the claim level





EALTH INSURANCE CLAIM FORM			
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- Not required
- Not mapped electronically





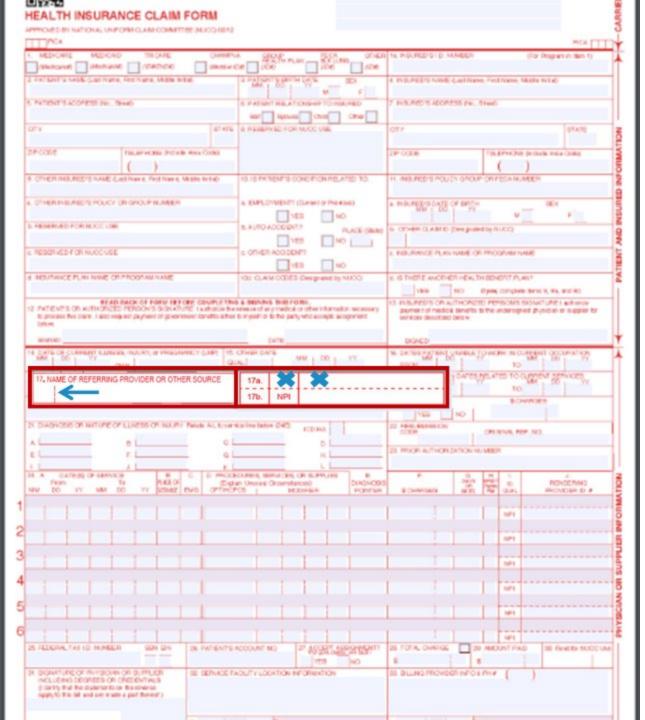
- Not required
- Six-digit date (MM/DD/YY) or eightdigit date (MM/DD/CCYY) when patient is employed and unable to work in current occupation
- An entry in this field may indicate employment-related insurance coverage (e.g., MSP workers' compensation)

No.	Claim Description	Loop	Field	Data Element Description	Requirements
16	Dates patient unable to work in current occupation (from and to)	2300	DTP03 (360)	Initial disability period start	Enter the date(s) when patient is employed and unable to work
			DTP03 (361)	Initial disability period end	in current occupation. An entry here may indicate employment related insurance coverage.





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#### Line Items 17 and 17b

- Type of specialty legally eligible to order and refer Part B clinical laboratory and imaging services
- First and last name of referring or ordering physician as it appears in PECOS
  - Qualifier DN, DK or DQ to left of vertical line
  - Do not use Item 17a
- List NPI of referring, ordering or supervising physician or NPP in Item 17b





## **EMC Equivalent Lines** 17 and 17b

• Electronic Data Interchange: Medicare Secondary Payer **ANSI Specifications for 837P** 

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Name of Referring physician or other source	2310A	NM103 (DN)	Referring provider last name	
			NM104	Referring provider first name	
			NM105	Referring provider middle name	Required if claim involved a referral or services were ordered.
		2420F**	NM103 (DN)	Referring provider last name	When reporting the provider who ordered services such as diagnostic and lab utilized the Referring Provider Name (2310A)
17			NM104	Referring provider first name	loop at the claim level. Required if a service or supply was ordered by a provider and that provider is a different entity if the rendering provider for this service line. When a claim involves multiple referring and/or ordering physicians, a sepa-
			NM105	Referring provider middle name	
	Name of Ordering physician	2420E	NM103 (DK)	Ordering provider last name	claim must be billed for each ordering pressures, a separate
			NM104	Ordering provider first name	]
			NM105	Ordering provider middle name	
17a	Other ID number of Referring physician				
17b	NPI	2310A	REF02 (1C)	Referring provider primary ID	
			REF02 (1C)		Enter "XX" in the NM108 to indicate an NPI is present in the
			REF02 (1C)	Ordering provider primary ID	NM109. Enter the NPI of the referring/ordering physician listed in Item 17







#### HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLASS COMMITTEE SELECT 02/12 Medicand Philosoph / / / / / / / / 2 PATERITY SAME CAST Name, First Name, Under System CPUILTED'S NAME CARD NAME OF STREET 5. PATIENT'S ACCOMESS DAY, SHARE S PATISHT HIS AT COM-EP TO HOUSED INSURED SADORESS Per Steel ist ippus Orio Oher STATE SUPERSONSE FOR MUCO USE SPCCOS Figure 1994 Indiele Aves Code 15, 8794 CNS (Include Avea Code) 9. CTHER HIS. RESYS NAME Cost Name . First Name . Mixte In his 4. CTHER INSURED'S POLICY OR GROUP HUMBER A EMPLOYMENTY (Current or Provious) D. PROBRIGO FOR MICC. USE B. AUTO ACCOUNT? D. OTHER CLASH D (Designated by BUCC) e regarded for succlude OTHER ACCIDENTS INSURANCE PLAN NAME OF PROSPAN NAME 1980 4. NEUTANCE PLAN NAME OF PROGRAM NAME I. IS THERE ANOTHER HEW, THREEPIT PLANT 1996 NO Dying complete Berlin N. Wa. and Ro. BEAD BACK OF FORM REFORE COMPLETING A BENANCE BUTCHER. 2 PATIENTS OF AUTHORIZED PERSONS SIGNATURE: Laufuture financiate of any medical or other information receiving I PASLIFIED S OF ALTHORIZED PERSONS SYSTATURE I MELVION payment of needed benefits to the undersigned physician or supplier for to process this claim. I also keep and payment of government bandits after to meet to the party who accept acceptment OHE. I NAME OF REFERENCE PROVIDER ON OTHER SOUNCE 179 191 19 ADDITIONAL CLANSINFORMATION Susquated to 19200 CPE SOLUE, FEEF, INC. B. PRIOR AUTHOR ZATION NUMBER CHONOR **PICHOCRINO** VER GE. SERVICE FACILITY LOCATION INFORMATION INCLUDEND DEOPRES OF CREDENTINGS 5 cartly that the stutements or this revenue opply to the tall and one waste a part flower? )

- Not required
- Admission and discharge hospital care codes related to services

- 18	Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		Hospitalization dates	2300	DTP03 (435)	Related hospitalization admission date	DTP01 Admission or Discharge qualifier 435 or 096
	18			DTP03 (096)	Related hospitalization discharge date	Enter the date when a medical service is furnished as a result of, or subsequent to, a related hospitalization. DTP (435) is required when 2300. CLM05-1 = 21, 51 or 61





- Certain claim submissions do not always require an attachment
  - Enter certain dates, facts or information about service(s)
    - Routine foot care
    - Hematocrit/hemoglobin
    - Homebound
    - Not otherwise classified codes/drugs
    - Shared post operative care
    - Demonstration/clinical trails
    - Anti-markup/purchased tests
    - Claim notes





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# EMC Equivalent Line 19

- Loops2300/2400/2310D/2320/2420D
- Segment/fields may differ
- For loops and fields, refer to guide for electronic claims crosswalk
  - Medicare Part B CMS-1500
     Crosswalk for 5010 Electronic
     Claims





- Diagnostic tests subject to anti-markup price limitations
  - Item 32 is the NPI of the provider the test were purchased from
  - Item 33 is the billing provider

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		2400	PS101	Purchased Service Provider ID	Required if there are diagnostic tests subject to the anti-markup
20	Outside Lab charges	2400	PS102	Purchased Service charge amount	payment price limits. 2420B is required when a 2400 PS1 is
	Country Edu Changes	2420B	NM1	Purchase service provider	present. When submitting a PS1, you must also submit the facility info in 2310C or 2420C.





	HEALTH INSURANCE CLAIM FORM							-
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#### HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLASS COMMITTEE SELECT 02/12 (Midrand) (Midrado) (7040100) 2. Participing holds (Last Name, Fest Name, Matte System) PUBLISHED NAME CARD NAME OF STREET S. PATIENT'S ACCORDED INC., SHARE S PATISHT HIS AT COMPRET TO HOUSED INSURED SHORTSTon, Steel Set Spouse One Other STATE OF RESERVED FOR MUCO USE SPCCOS Fig. ar HE 200 Inches Res Code III, 8 PHICKIE (Include Avea Code) A. OTHER INSURED/S POLICY OR GROUP ILLINEER A EMPLOYMENTY (Current or Provious) S. PRINKRUKO FOR MUCC USE B. AUTO ACCOUNT? D. CEHRICLASKE (Designated by BUCC) e, regarded from NUCCUSE CONTRACTOR ACCURATE INSURANCE PLAN NAME OF PROSPAN NAME 4. NOUTWICE PLHI NAME OF PROGRAM NAME I G THERE ANOTHER HEW THRENDY PLANT 1996 NO Dyes Conghes Bert 9, 94, and 95 BEAD BACK OF FORM REFORM COMPLETING A BROWN BY DRIV. 2. PVP CVPS OF AUTHORISES PERSONS SIGN (FUEL LAMBOUR to remain of any medical or other information receiving). INSURED'S OR AUTHORIZED PERSONS SKINKTURE I MENKIN payment of medical benefits to the undersigned physician or supplier for It grows the part, lists keeping pyrent of gradients tanditis after to medify it the part, who accept accept and CHAIN NAME OF REFERENCE PROVIDER OR OTHER SOURCE 179 199 9 ADDITIONAL CLAIM INFORMATION Strangasted to 19700 O CAPTROPLANT **BCHARGET** YES NO FRICALISM CO. CPE SOLUE, FEEF, INC. PRINCIPALITHORIZATION NUMBER PICHOCRINO INCLUDEND DEGREES OF CREDENTINGS 5 can't be the student of the reverse apply to the fall and one made a part through

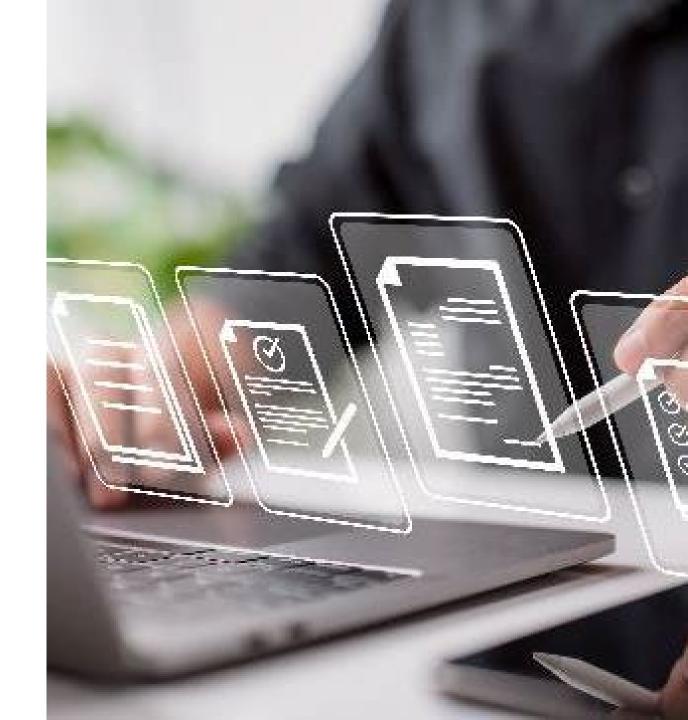
- Enter up to 12 diagnoses in priority order
  - primary, secondary condition
- Code to highest level of specificity for service
- ICD-10-CM indicator should be "0" for paper submitters





# **EMC Equivalent Line** 21

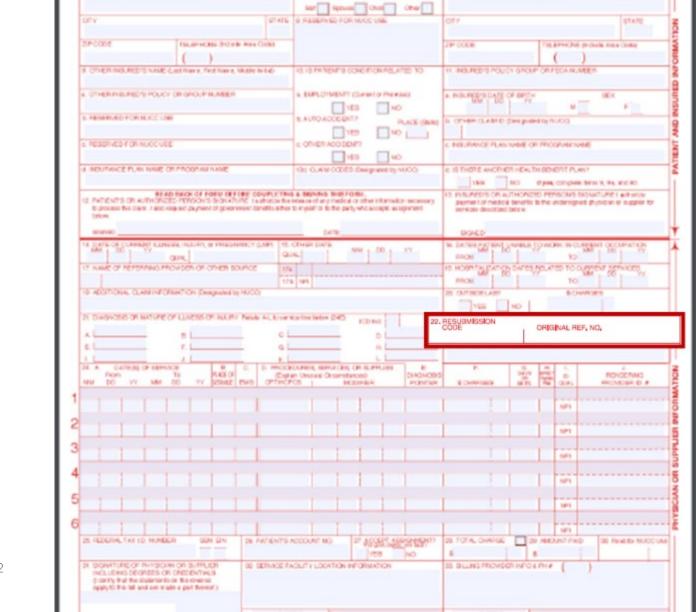
- Loops 2300
  - Segment/fields HI01-02-HI12-02
- For loops and fields, refer to guide for electronic claims crosswalk
  - Medicare Part B CMS-1500 Crosswalk for 5010 Electronic **Claims**







- Not required
- Not mapped electronically



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INSURED S ADDRESS Per Steel

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNFORM CLAIM COMMITTEE SALICO (2012)

(Studiose) (Studiose) (CADACA)

5. PATIENT'S ACCRESS NO. SENSO





#### HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLASS COMMITTEE SNUCCHOEST (Midrand) (Midrado) (7040100) 2. Participing holds (Last Hama, Fest Name, Matte Matte PUBLISHED NAME CARD SINGS FINE STORES MAKE THE A S. PATIENT'S ACCORDED INC., SHARE S PATISHT HIS AT COMPRET TO HOUSED INSURED SHORTSSIPE, Steel int lipous Cha Char STATE OF RESERVED FOR MUCO USE SPCCOS Fig. ar HE 200 Inches Res Code III, 8 PHICKIE (Include Avea Code) A. OTHER INSURED/S POLICY OR GROUP ILLINEER A EMPLOYMENT (Current or Provious) S. PRINKRUKO FOR MUCC USE B. AUTO ACCOUNT? D. CENER CLASS D. Clerk proded to B VCCC e, regarded from NUCCUSE INSURANCE PLAN NAME OF PROSPAN NAME 4 NEUTWICE PLHI NAME OF PROGRAM NAME I G THERE ANOTHER HEW, THREE OT PLANT 1996 NO Dyes complete Berli 9, 94, and 95 BEAD BACK OF FORM REFORE COUPLETING A BENNING THE FORE. 2. PVP ENT'S OF AUTHORICED PERSON'S SIGN (FURE 1 Authorize the release of any medical or other information receiving). INSURED'S OR AUTHORIZED PERSONS SYSTATURE I ARRIVA pamer to hedge benefits to the indenigned physician or outpiler for to process that older it also request payment of gradenesses bandles after to metall to the party should apply an opinion CHAIN NAME OF REFERENCE PROVIDER OR OTHER SOURCE 179 199 9 ADDITIONAL CLAIM INFORMATION Strangasted to 19700 **BCHARGET** YES NO O PRINCESON COL OFF SOUN, FREE, INC. 23. PRIOR AUTHOFIZATION NUMBER 30 Fendilly NUCCUM INCLUDING ODGREES OF CREDIDITING 5 cards that the studengridory the sovered apply to the fall and one made a part through

- Ambulance ZIP code point of pick up
- CLIA ten-digit certification number
- NPI of the home health or hospice facility
  - Billing for CPO, HCPCS G0181 (HH) or G0182 (hospice)
- Prior Authorization
  - Unique Tracking Number
- Seven-digit IDE number when investigational device is used in an FDA-approved clinical trial



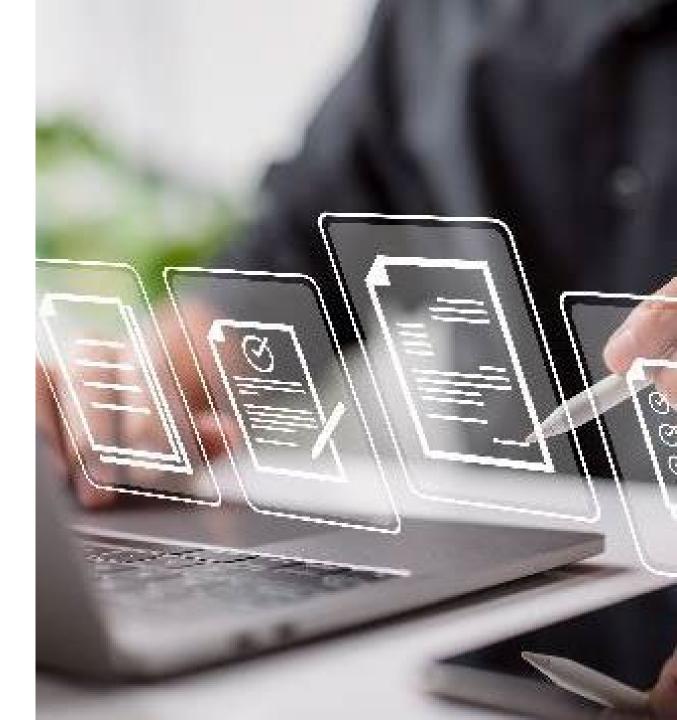


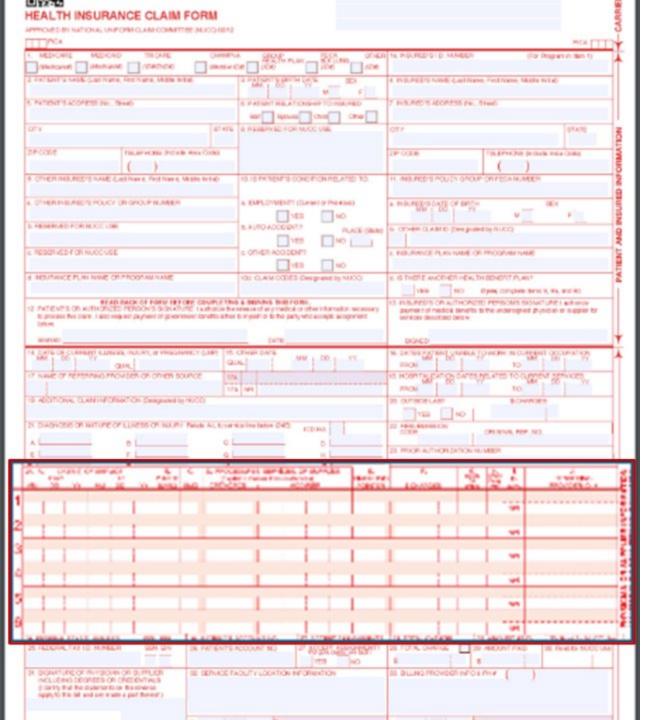
# **EMC Equivalent Line** 23

- Loops 2300/2300B/2310E/2310F
  - Segment/fields REF02 with appropriate qualifier
- For loops and fields, refer to guide for electronic claims crosswalk
  - Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims









## Line Items 24A-24J

- Paper claim contains six-line items
  - 24A: Date of service
  - 24B: Place of service
  - 24C: Not used
  - 24D: CPT/HCPCS, modifier(s)
  - 24E Diagnosis code pointer
  - 24F: Charge/fee for service
  - 24G: Units
  - 24H: Not used
  - 24l: Not used
  - 24J: Rendering/performing physician or NPP



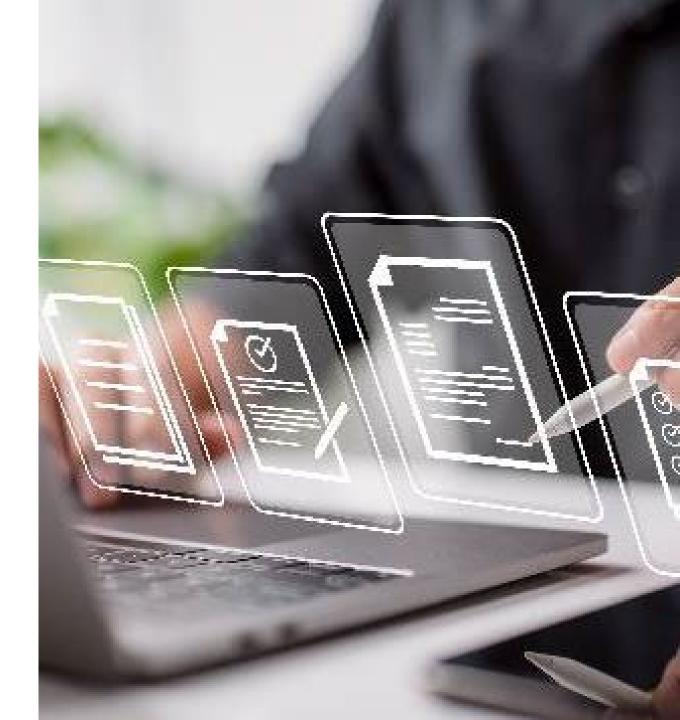


# **EMC Equivalent Lines** 24A-24J

- Loops
  - 2010AA/2300/2310B/2400/2420A
- Segment/fields
  - DTP/CLM/SV101-107/REF/NM109/AMT
- For loops and fields, refer to guide for electronic claims crosswalk
  - Medicare Part B CMS-1500 Crosswalk for 5010 Electronic **Claims**







#### HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLASS COMMITTEE SELECT 02/12 Medicand Philosoph / / / / / / / / / 2 PATERITY SAME CAST Name, First Name, Under System CPUILTED'S NAME CARD NAME OF STREET 5. PATIENT'S ACCOMESS DAY, SHARD S PATISHT HIS AT COMPRET TO HOUSED INSURED S ADDRESS DW. SHALL iat ipous One One STATE SUPERSONSE FOR MUCO USE SPCCOS TSUAPPROPRIES INCHES RIVER CORD 15, 8794 CNS (Include Avea Code) 9. CTHER INDURED'S NAME Cast Name, First Name, Middle Initial 4. OTHER INSURED'S POLICY OR GROUP ILLMEEN A EMPLOYMENTY (Current or Province) D. PROBRUGO FOR MUCC LIMI B. AUTO ACCOUNT? D. CETHER CLASHED (Designated by BUCC) e, regarded from NUCCUSE OTHER ACCIDENTS INSURANCE PLAN NAME OF PROSPAN NAME 100 4. NEUTANCE PLAN NAME OF PROGRAM NAME OC CLAW CODES Designated by NUCC I. IS THERE ANOTHER HEW, THREEPIT PLANT 1996 NO Dying complete Berlin N. Wa. and Ro. BEAD BACK OF FORM REFORE COMPLETING A BENANCE BUTCHER. 2 PATIENTS OF AUTHORIZED PERSONS SIGNATURE: Laufuture financiate of any medical or other information receiving I PASLIFIED S OF ALTHORIZED PERSONS SYSTATURE I MELVION payment of needed benefits to the undersigned physician or supplier for to process this claim. I also keep and payment of government bandits after to meet to the party who accept acceptment OH. I NAME OF REFERENCE PROVIDER ON OTHER SOUNCE 179 199 FROM 19 ADDITIONAL CLANSINFORMATION Susquated to MICCO III CRITICIPALARI YES NO COSE COSE CPE SOLAR, FEEF, SVC. B. PRIOR AUTHOR ZATION NUMBER CHONOR **PICHOCRINO** 25, FEDERAL TAX LD, NUNBER SSN EIN VER () can't, that the statements on the revenue of apply to the fall and are made a part threeof.)

## Line Item 25

 Enter provider of service Federal Tax ID, EIN or SSN of billing provider/group

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
					_
	Federal Tax ID number		REF02	Billing Provider Tax ID	
25	SSN Indicator	2010AA	REF01	Social Security number	Enter the provider of service Federal Tax ID/EIN (EI) or SSN (SY) of the billing provider/group.
	EIN Indicator		REF01	Employer's ID number	



- Enter patient's account number assigned by provider
- An account number will be returned up to 20 characters

Iten No.	Claim D	escription	Loop	Field	Data Element Description	Requirements
26		s Account mber	2300	CLM01	Provider Assigned Account number	Enter the patient's account number assigned by the provider of service's accounting system. As a service, any account number will be returned to you up to 20 characters.





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- Assignment: check yes or no
- Mandatory assignment for certain services
  - Clinical diagnostic laboratory services and physician lab services
  - Physician services to individuals dually entitled to Medicare and Medicaid
- Mandatory assignment for certain practitioners and providers
  - Physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
27	Accept Assignment?	2300	CUNIT	Assignment or Plan Participation code	A=Assigned B=Assignment accepted on Clinical Lab services only C=Not assigned





# Line Items 28, 29 and 30

- Item 28 is total charges on claim
- Item 29 leave blank
  - Often misunderstood
  - Allocates payment to beneficiary
- Item 30 is not used

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
28	Total Charges	2300	CLM02	Total claim charge amount	Enter total charges for services.
29	Amount paid	2300	AMT02	Total patient amount paid	AMT01 Amount qualifier code=F5 Required if the patient has paid any amount towards the claim for covered services only.





PROJECT BY NATIONAL UNIFORM CLANS COMMITTEE SALICO (CONS.)	FORTT
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#### HEALTH INSURANCE CLAIM FORM APPROVED BY NATIONAL UNIFORM CLASS COMMITTEE SNUCCHOEST (Midrand) (Midrado) (7040100) 2. Participing holds (Last Name, Fest Name, Matte System) C PUBLISHED'S NAME CONTRIBUTE ON PROTOGRAPH SALES S. PATIENT'S ACCORDED INC., SHARE INSURED SHORTSTon, Steel Set Spouse One Other STATE OF RESERVED FOR MUCO USE SPCCOS Fig. ar HE 200 Inches Res Code III, 8 PHICKIE (Include Avea Code) A. OTHER INSURED/S POLICY OR GROUP ILLINEER A EMPLOYMENTY (Current or Provious) S. PRINKRUKO FOR MUCC USE B. AUTO ACCOUNT? D. CENER CLASS D. Clerk proded to B VCCC e, regarded from NUCCUSE INSURANCE PLAN NAME OF PROSPAN NAME 4. NEUTANCE PLAN NAME OF PROGRAM NAME I G THERE ANOTHER HEW, THREE OT PLANT 1800 NO O'PHIS CONCRETE BYOLK N. WA. MYG. RD. BEAD BACK OF FORM REFORM COMPLETING A BROWN BIRD FORM. 2. PVP CVPS OF AUTHORICED PERCONS SIGN PURE 1 Authorize the release of any medical or other information receiving. INSURED'S OR AUTHORIZED PERSONS SKINKTURE I MENKIN payment of medical benefits to the undersigned physician or supplier for to process the claim. I also keeped payment of government bandits after to metall to the party sho accept autoprinent NAME OF REFERENCE PROVIDER OR OTHER SOURCE 179 199 9 ADDITIONAL CLANSINFORMATION Seeguated to 19200 150 NO COSE COSE CPE SOUN, PEP. NO. 9. PRINCE AUTHORIZATION NUMBER CHOMOR PICHOCRINO INCLUDING DEGREES OR CREDENTIALS If certify that the statements on the reverse apply to this bill and are made a part thereof.)

- Paper submitters
  - Signature of provider or representative and six-digit or eight-digit date form was signed
- Electronic submitters
  - Y=Provider signature on file
  - N=Provider signature not on file

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
30	Balance due	N301			
31	Signature of physician or supplier including degrees or credentials	2300	CLM06	Provider or supplier signature indicator	Y=Provider signature is on file N=Provider signature is not on file





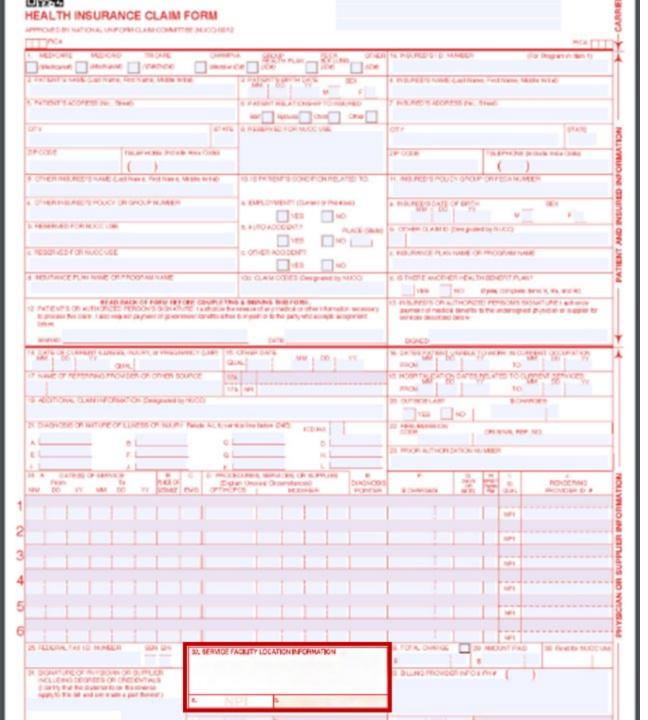
- Place of service required on all claims
  - Name, address and ZIP code

		NM103 (77)	Laboratory or Service Facility Name	NM101 Entity Identifier code=77 - Service Location Required
		N301	Laboratory or Service Facility address 1	when the location of the service is different than that carried in 2010AA-Billing Provider (Item 32). Enter the name, address city,
	2310C	N302	Laboratory or Service Facility address 2	state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify
		N401	Laboratory or Service Facility city	the supplier's name, address, and zip code. Required when the
		N402	Laboratory or Service Facility state	location of health care service is different than that carried in the
Name and address of	of	N403	Laboratory or Service Facility ZIP code	Billing Provider Name (2010AB) loops.
facility where services were rendered (if other	other	NM103 (77)	Laboratory or Service Facility Name	Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of
than home or office).		N301	Laboratory or Service Facility address 1	service is different than the HPSA billing address. If an independent laboratory is billing enter the place where the test
		N302	Laboratory or Service Facility address 2	were performed. Complete this information for all laboratory work performed outside a physician's office. If the service was
	24200	N401	Laboratory or Service Facility city	referred to an outside lab, enter the reference labs name and
		N402	Laboratory or Service Facility state	address. Providers of service must identify the supplier's name,
		N403	Laboratory or Service Facility ZIP code	address and NPI when billing for anti-markup tests. If the acquisition provider is out of jurisdiction, you should use the billing provider's NPI. Only bill one unique facility number per claim.





EALTH INSURA	NCE CLAIM FOR	RM						
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## Line Items 32 and 32a

- All claims require place of service line item 32
  - Ambulance claims
  - Laboratory or service facility
  - Mammography certification
- Purchased test require both 32 and 32a

		2310C	NM109 (77) NM109	Laboratory/Facility Primary Identifier		
		2400	(77) P8101	Purchased service provider identifier		
374	37a NPI		2420B	NM101 NM108 NM109	Identification code qualifier =QB Identification code=XX	Enter the NPI of the Service Facility, Enter "XX" in the NM108 to indicate the NPI is present in the NM109.
		2300 NM10 NM10	NM101	Identification code Identification code qualifier =QR Identification code		
	2300		NM109	Identification code	1	
			REF01	Reference Identification qualifier =EW		
		REF02	Mammogram FDA number			





## Line Items 33 and 33a

- Required on all claims
  - Provider's billing name, telephone number, address and ZIP code
- Item 33a contains NPI of billing practice

tem No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Physician's supplier's		NM103 (85)	Provider last or organizational name	NM101 Entity Identifier code=85- Billing Provider
33	billing name, address, 2010AA or 2010AB NM104 Provider first name 2010AB NM105 Provider middle initial NM105 Provider middle initial provider middle initial provider middle initial provider middle initial provider address 1				NM101 Entity Identifier=87-Pay-to-provider
		NM102 Entity Type code 1 Person 2 Non-Person Entity			
			N402 N403	Provider state Provider ZIP code	Enter the provider or service/supplier's billing name, address, a code and telephone number. Must be a physical address with name days 20 code.
33a	NPI	2010AA	PERO4 NM109 (85)	Provider phone number  Provider ID	NATIO1 Entity blandfler code=85.88mg Provider NATIO1 Entity blandfler code=87.4°sy to-provider Entity blandfler code=87.4°sy to-provider Entity National State of the State of
330	filling Taxonomy Number	2000A 2010AA	PRV02 PRV03	Taxonomy number	Qualifier PXC





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# Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

#### Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

The information contained in this crosswalk is for reference purposes only.

<sup>\*\* =</sup> Use if different than information given at the claim level. 7/6/2012 - KJT 1

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements	
			SBR09	Claim editing indicator code	Must = MB for Medicare Part B	
1	1 Type of Health Insurance	2000B	SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary	
			SBR02	Individual Relationship Code	Individual relationship code (18 = Self)	
1a*	Patient's Medicare Beneficiary ID Number (MBI)	2010BA	NM109	Subscriber Primary Identifier	Patient's Medicare Beneficiary ID Number (MBI)	
	2 Patient's Name	2010BA or 2010CA	NM103	Last Name	Enter the patient's name as shown on their Medicare card	
2			NM104	First Name		
			NM105	Middle initial	Enter the patient's harrie as shown on their Medicare card	
			NM107	Suffix (e.g., Jr. Sr.)		
3	Patient's Birth Date	2010BA	DMG02	Birth Date	Enter the patient's birth date. Must be formatted as CCYYMMDD.	
	and gender	201000	DMG03	Gender	Date qualifier (DMG01) = D8	
	Insured's name (When	nere is insurance mary to Medicare, 2330A	NM103	Other insured last name	Enter the insured's name. Required if any other payers are	
4*	primary to Medicare,		NM104	Other insured first name	known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information	
	are required items.)	Items 4, 6, 7, and 11 are required items.)		NM105	Other insured middle name	reported in the 2010BA Loop does not repeat in the 2330A Loop.





<sup>\* =</sup> If Medicare Secondary Payer or Medigap is involved, refer to the 5010 TR3.

# Claim Rejection Reminders

- Claim rejections CO16, MA130
  - Claims received that contain incomplete or invalid information will be "rejected" and returned as unprocessable
- Unprocessable claims have
  - No appeal rights
  - No reopening rights
- Resubmit a new claim with corrected information
- Unprocessable Claim Rejections and Corrections



# Resources, References and Tools

# Resources and References

- NGS website
  - CMS-1500 Claim Form Completion Instructions
  - Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims
  - Top Claim Errors
- CMS website
- Place of Service Code Sets
- CMS IOM Publication 100-04, Medicare Claims Processing Manual
  - Chapter 1, General Billing Requirements
  - Chapter 26, Completing and Processing Form CMS-1500



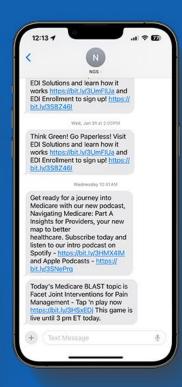


# Questions?

Thank you!







Connect with us on social media





Text NEWS to 37702: Text GAMES to 37702



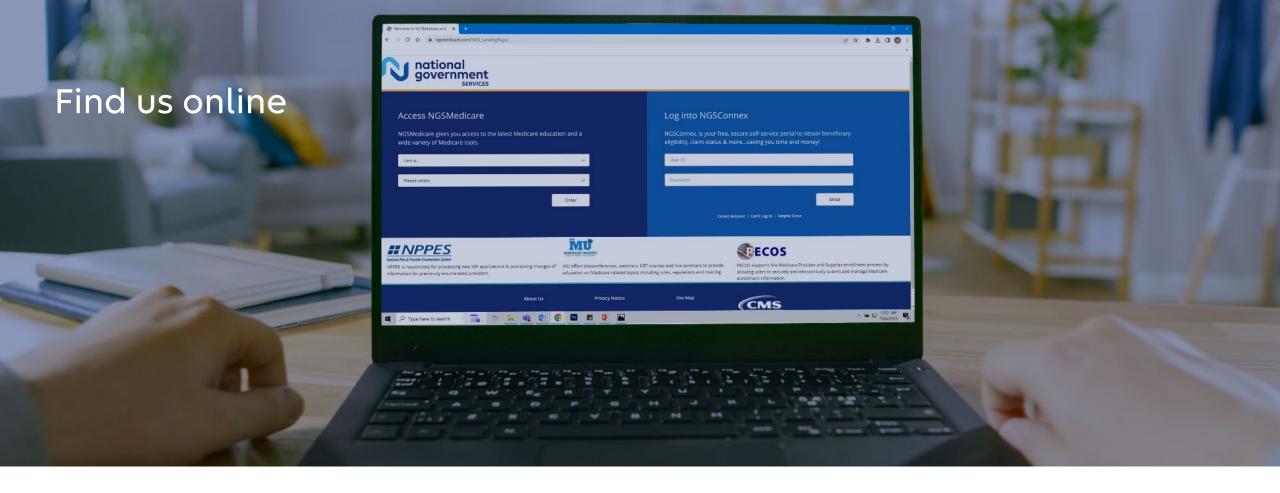
www.MedicareUniversity.com

Self-paced online learning











#### www.NGSMedicare.com

Online resources, event calendar, LCD/NCD, and tools



#### IVR System

The interactive voice response system (IVR) is available 24-hours a day, seven days a week to answer general inquiries



#### **NGSConnex**

Web portal for claim information



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