



# Proper Medicare Part B Claim Submissions

7/26/2023





#### Today's Presenters

# Provider Outreach and Education Consultants

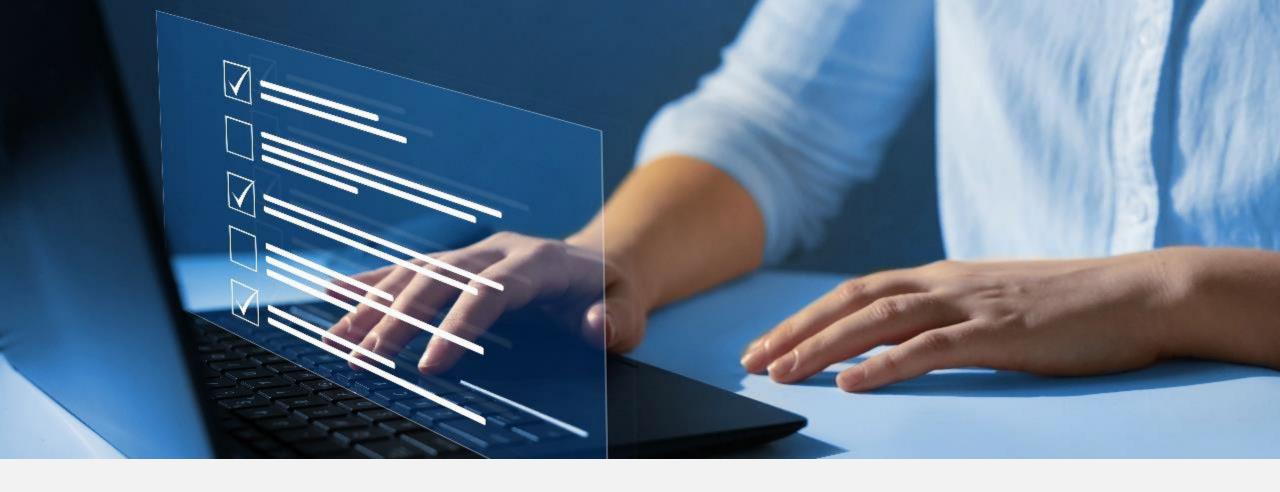
- Arlene Dunphy, CPC
- Carleen Parker









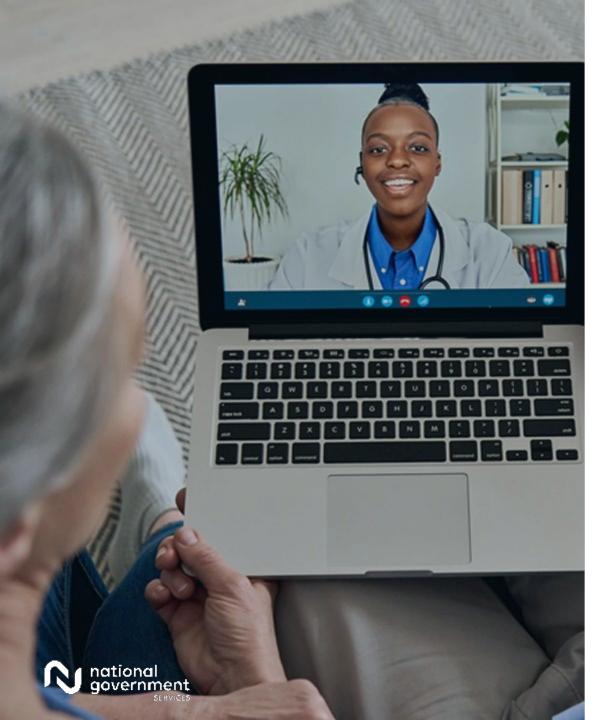


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#### Recording

Attendees/providers are never permitted to record (tape record or any other method) our educational events. This applies to webinars, teleconferences, live events and any other type of National Government Services educational events.

#### **Objectives**

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** 

**Claims Filing Time Limit** 

Administrative Simplification Compliance Act

Paper and Electronic Claim Overview

Resources, References and Tools







# Claim Form Requirements



# Claim Submission Requirements

- Paper
  - Original CMS-1500 Claim Form
  - 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



# 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</u> <u>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







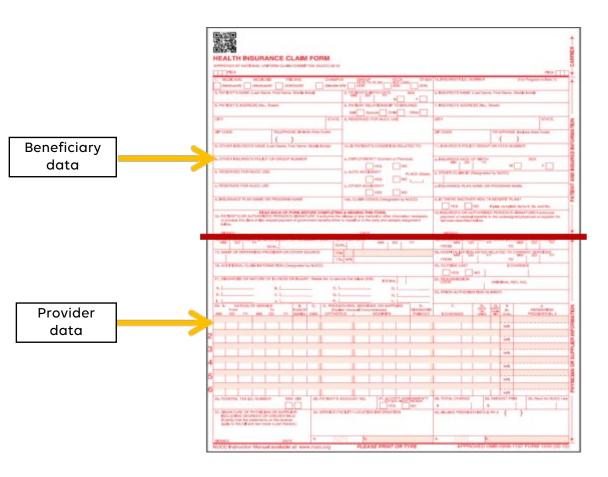
# **ASCA Regulations**

- 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



# 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

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	(Medicare#)	(Medicaid#)	(ID#/DoD#)	(Member ID#)	HEALTH PLAN (ID#)	(ID#)	(ID#)

	Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
ı				SBR09	Claim editing indicator code	Must = MB for Medicare Part B
	1	Type of Health Insurance	2000B	SBR01	Payer Responsibility Sequence Number Code	Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary
ı				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); if you use lowercase letters, our system will convert them to uppercase letters. MBIs are assigned by SSA

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

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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

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements				
		2010BA	NM103	Last Name					
2	Patient's Name					or		NM104	First Name
	rationt's Ivallic	2010CA	NM105	Middle initial	Enter the patients harne as shown on their medicale card				
		2010CA	NM107	Suffix (e.g., Jr. Sr.)					

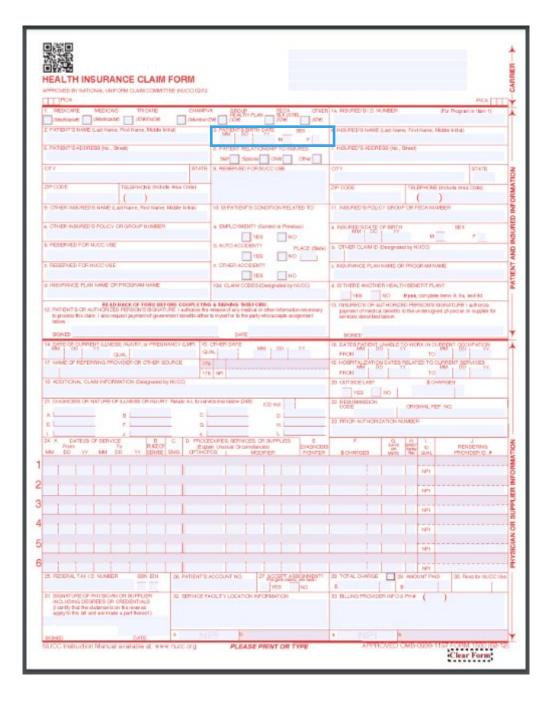




 Patient's eight-digit date of birth (MMDDCCYY) and check the appropriate box for patient's sex



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







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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

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Insured's name (When there is insurance		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

5. PATIENTS ADDRESS (No., Street)

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

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





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



Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
6*	Patients relationship to insured if (Complete this Item only when Items 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

7. INSURED'S ADDRESS (No., S	Street)	
СІТҮ		STATE
ZIP CODE	TELEPHONE (Include Area	Code)

Item 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
1	Insured's address and telephone number (Complete this MSP 233		N302	Other subscriber address line 2	payers are known to potentially be involved in paying this claim
7*		2330A	N401	Other subscriber city name	and the information is available. If the insured is the patient this
1	claims)		N402	Other subscriber state code	would be blank and information reported in the 2010BA Loop
	5.02.71107		N403	Other subscriber ZIP code	does not repeat in the 2330A Loop.





EALTH INSURANCE CLAIM FORM	r					
PERCENT INSURANCE CENTRIFORM CLAM COMMITTEE NUCC						BCA FTTT
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ALTH INSURANCE CLAIM FORM			
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- Reserved for future NUCC use
- Not mapped electronically

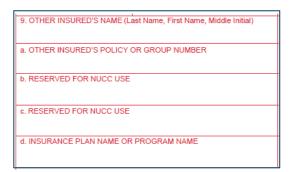
8. RESERVED FOR NUCC USE





## 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







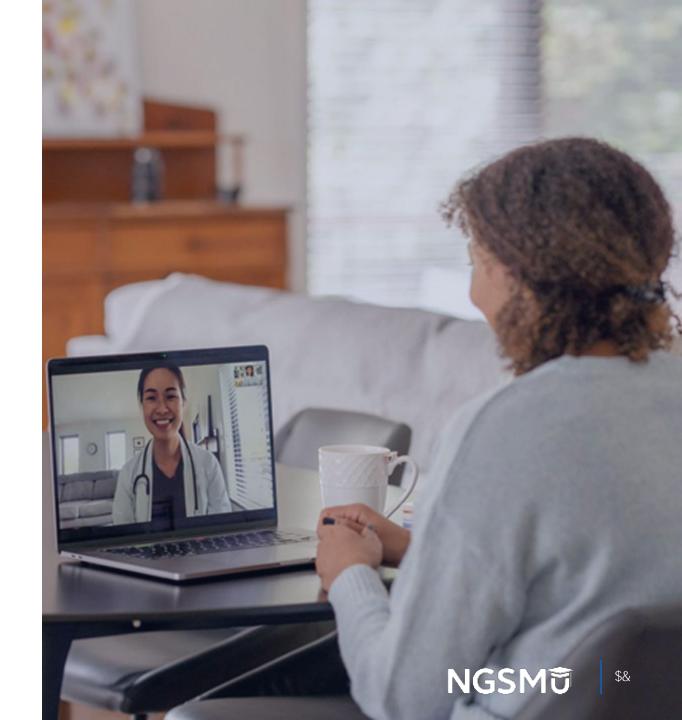
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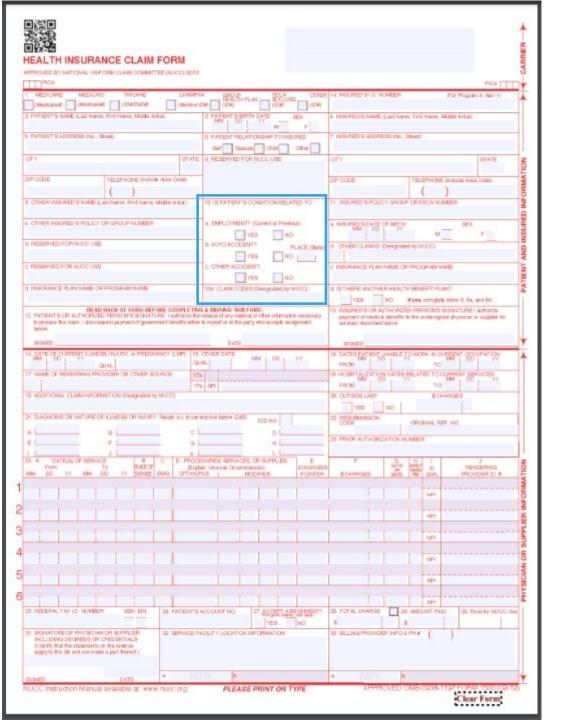
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Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Other insured's		NM103	Other insured last name	
9*	Name (Last, First,	2333A	NM104	Other insured first name	Name of insured for Medigap plan
	Middle Initial)		NM105	Other insured middle name	
		2333A	NW108	Identification Code Qualifier (MI Member Identification Number)	Medigap policy ID
	Other insured's policy		NM109	Other insured identifier	Medigap
Sw*	or group number (Medinan onto)	or group number	P Primary Si Secondary T Tertiary		
			98R03	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
96	school name (Medigap	23338	N432	Other payer state code	other payers are known to potentially be involved in paying this claim.
	Address)		N400	Other payer ZIP code	Can't
96"	ineurance plan name or program name	23305	NW108	Other payer identification Code Qualifier	Medigap plan only
			NM109	Payer last or organization name	
			NM103	Insured's group/policy no.	]

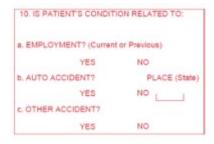






# Line Items 10a, 10b, and 10c

- 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?		CLM11- 1	Auto accident indicator (AA)	
b, c	Place (State)	2300	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.





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10d. CLAIM CODES (Designated by NUCC)

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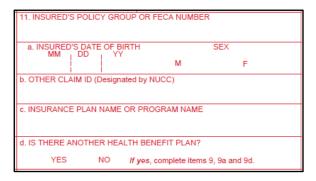


HEALTH INSURANCE CLAIM FOR	RM						
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NUCC Instruction Manual available at: www.nucc	OF THE REAL PROPERTY.	SE PRINT OR TY	_		WED OWN	TORSE STORY	Clear Form

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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



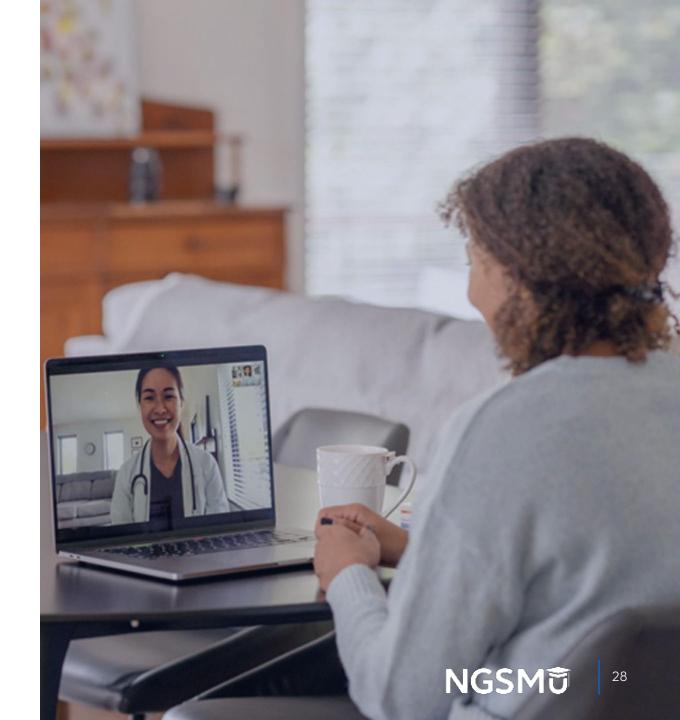




# EMC Equivalent Lines 11, 11a-11c

- Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims
- Electronic Data Interchange: Medicare Secondary Payer ANSI Specifications for 837P
  - Indication of MSP
  - Insurance type code
  - Coordination of Benefits Payer Paid Amount Claim Level
  - Coordination of Benefits Allowed Amount Claim Level
  - Claim Contract Information Claim Level
  - Claim Adjudication Date Claim Level
  - Line Adjudication Information
  - Line Adjustments
  - Line Adjudication Date





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- 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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

DATE





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

 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
 SIGNED

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
13	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

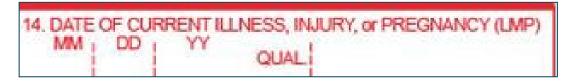




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- Six-digit or eight-digit date of current illness, injury, or pregnancy (LMP)
- Do not enter qualifier (QUAL) in item 14



Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	230	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





- Not required
- Not mapped electronically







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



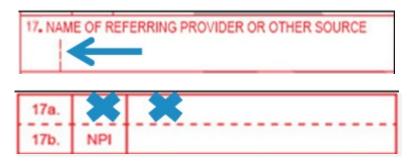
Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
40	Dates patient unable to work in current	0000	DTP03 (360)	Initial disability period start	Enter the date(s) when patient is employed and unable to work
16	occupation (from and to)	2300	DTP03 (361)	Initial disability period end	in current occupation. An entry here may indicate employment related insurance coverage.





#### 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



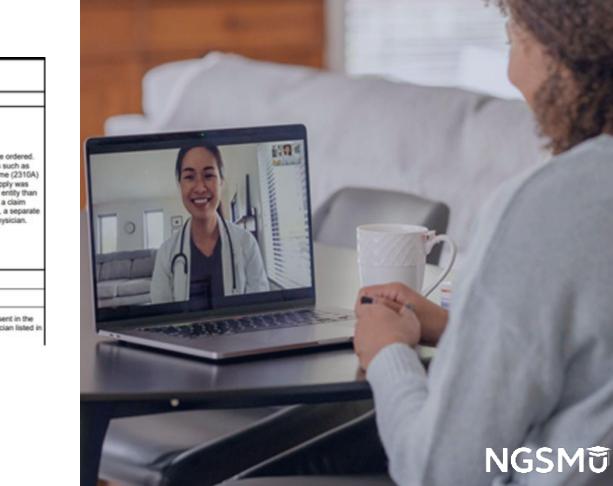




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# EMC Equivalent Lines 17 and 17b

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	38				
			NM103 (DN)	Referring provider last name	
		2310A	NM104	Referring provider first name	]
	Name of Referring		NM105	Referring provider middle name	Required if claim involved a referral or services were ordered.
	physician or other NM103 Referring provider last name When reporting the provider	When reporting the provider who ordered services such as diagnostic and lab utilized the Referring Provider Name (2310A)			
17			loop at the claim level. Required if a service or supply was ordered by a provider and that provider is a different entity than		
			NM105	Referring provider middle name	the rendering provider for this service line. When a claim involves multiple referring and/or ordering physicians, a separ
			NM103 (DK)	Ordering provider last name	claim must be billed for each ordering/referring physician.
	Name of Ordering physician		NM104 Ordering provider first name	]	
			NM105	Ordering provider middle name	1
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





EALTH INSURANCE CLAIM FORM			
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/4	2		RCs FT
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- Not required
- Admission and discharge hospital care codes related to services



Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Hospitalization dates	DTP03 (435)	Related hospitalization admission date	DTP01 Admission or Discharge qualifier 435 or 096	
18	related to current service (From and To)	2300	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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)





HEALTH INSURANCE CLAIM FORM			
PHYCHED BY NATIONAL UNIFORM CLAM COMMITTEE (NUCC)	KD/12	PCA	_
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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		2400	PS102	Purchased Service charge amount	payment price limits. 2420B is required when a 2400 PS1 is
20	Odiside Lab Glarges	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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- 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

21. DIAGNOSIS OR NA	TURE OF ILLNESS OR INJURY	Relate A-L to service line below (24E)	ICD Ind.
A	В.	C	D
E	F.	G	Н.
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# 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





EALTH INSURANCE CLAIM FORM			
PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 00/12			
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Not required

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22. RESUBMISSION ORIGINAL REF, NO,
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Not mapped electronically





- 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
- Seven-digit IDE number when investigational device is used in an FDA-approved clinical trial

23, PRIOR AUTHORIZATION NUMBER	





HEALTH INSURANCE CLAIM FORM		
APPROVED BY NATIONAL UNIFORM CLAM COMMITTEE BUCCH CON- LITTURICA		804 FT
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## **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
  - 24I: Not used
  - 24J: Rendering/performing physician or NPP

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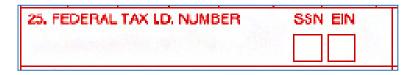
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# EMC Equivalent Lines 24A-24J

- 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

 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	





EALTH INSURANCE CLAIM FOR												
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ALTH INSURANCE CLAIM FORM			
ROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC			
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- Enter patient's account number assigned by provider
- An account number will be returned up to 20 characters

26. PATIENT'S ACCOUNT NO.

No.	laim Description	Loop	Field	Data Element Description	Requirements
26 P	Patient's Account number	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.





EALTH INSURANCE CLAIM FORM			
PROVED BY HATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/42			
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to process this claim. I also request payment of government banefits either to below.	in pall or to the party who accepts unaignment	bendoes described below	
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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

Hem No.	Claim Description	Loop	Field	Data Element Description	Requirements
27	Accept Assignment?	2300	CUN07	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

28, TOTAL CHARGE	29. AMOUNT PAID	30, Rsvd for NUCC Use
\$	\$	

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.





EALTH INSURANCE CLAIM FORM			
PROVED BY NATIONAL UNPOPM CLAM COMMITTEE (NUCC) (CAV)		PICA	П
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to process the claim. I also request payment of government so with other trailing.	to myself or to the party who accepts as agreement	services described below.	
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- 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

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

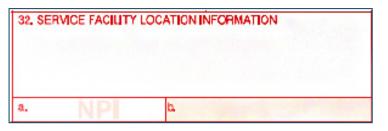
SIGNED DATE

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
	Date signed	N401			





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



Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Name and address of	2310C	NM103 (77) N301 N302 N401 N402 N403	Laboratory or Service Facility Name Laboratory or Service Facility address 1 Laboratory or Service Facility address 2 Laboratory or Service Facility city Laboratory or Service Facility state Laboratory or Service Facility ZIP code	NM101 Entity Identifier code=77 - Service Location Required when the location of the service is different than that carried in 2010AA-Billing Provider (Item 32). Enter the name, address city, state, and ZIP code of the location where the services were rendered. Providers of service (namely physicians) must identify the supplier's name, address, and zip code. Required when the location of health care service is different than that carried in the Billing Provider Name (2010AB) loops.
	facility where services were rendered (if other than home or office).	2420C**	NM103 (77) N301 N302 N401 N402 N403	Laboratory or Service Facility Name Laboratory or Service Facility address 1 Laboratory or Service Facility address 2 Laboratory or Service Facility city Laboratory or Service Facility state Laboratory or Service Facility ZIP code	Required if the service was rendered in a Health Professional Shortage Area (QB or QU modifier billed) and the place of service is different than the HPSA billing address. If an independent laboratory is billing enter the place where the test were performed. Complete this information for all laboratory work performed outside a physician's office. If the service was referred to an outside lab, enter the reference labs name and address. Providers of service must identify the supplier's name, 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.





#### 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



Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
		2310C		Laboratory/Facility Primary	
		2420C**	NM109 (77)		
		2400	PS101	Purchased service provider identifier	
		2420B	NM101	Identification code qualifier =QB	Enter the NPI of the Service Facility. Enter "XX" in the NM108 to
32a	NPI		NM108	Identification code=XX	indicate the NPI is present in the NM109.
		ı	NM109	Identification code	indicate the NP1 to present in the NM109.
		ı	NM101	Identification code qualifier =QB	
		2300	NM108	Identification code	
		2500	NM109	Identification code	
			REF01	Reference Identification qualifier =EW	
			REF02	Mammogram FDA number	
32b		N301			





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### 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



Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
Physician's supplie	Physician's supplier's	g name, address, 2010AA or	NM103 (85)	Provider last or organizational name	NM101 Entity Identifier code=85- Billing Provider
33	hilling name, address		NM104 NM105	Provider first name Provider middle initial	NM101 Entity Identifier=87-Pay-to-provider
	number		N301 N401	provider address 1 Provider city	NM102 Entity Type code 1 Person 2 Non-Person Entity
			N402 N403 PER04	Provider state Provider ZIP code Provider phone number	Enter the provider or service/supplier's billing name, address, zip code and telephone number. Must be a physical address with nine-digit ZIP code.
33a	NPI	2010AA	NM109 (85)	Provider ID	NM101 Entity Identifier code=85-Billing Provider NM101 Entity Identifier code=87-Pay-to-provider Enter the NPI for the Group Number or for the performing provider of service/supplier who is a member of a group practice Enter "XX" in the NM108 to indicate an NPI is present in the NM109
336	Billing Taxonomy Number	2000A 2010AA	PRV02 PRV03	Taxonomy number	Qualifier PXC







# 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		
	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B		
1 7			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			
2			NM104	First Name	Enter the patient's name as shown on their Medicare card		
			NM105	Middle initial	Enter the patient's harrie as shown on their Medicare card		
			NM107	Suffix (e.g., Jr. Sr.)			
2	Patient's Birth Date and gender	Patient's Birth Date	Patient's Birth Date	2010BA	DMG02	Birth Date	Enter the patient's birth date. Must be formatted as CCYYMMDD.
3		nder 2010BA	DMG03	Gender	Date qualifier (DMG01) = D8		
	Insured's name (When there is insurance 4* primary to Medicare,	there is insurance primary to Medicare, 2330A Network 11	NM103	Other insured last name	Enter the insured's name. Required if any other payers are		
4*			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.		

<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





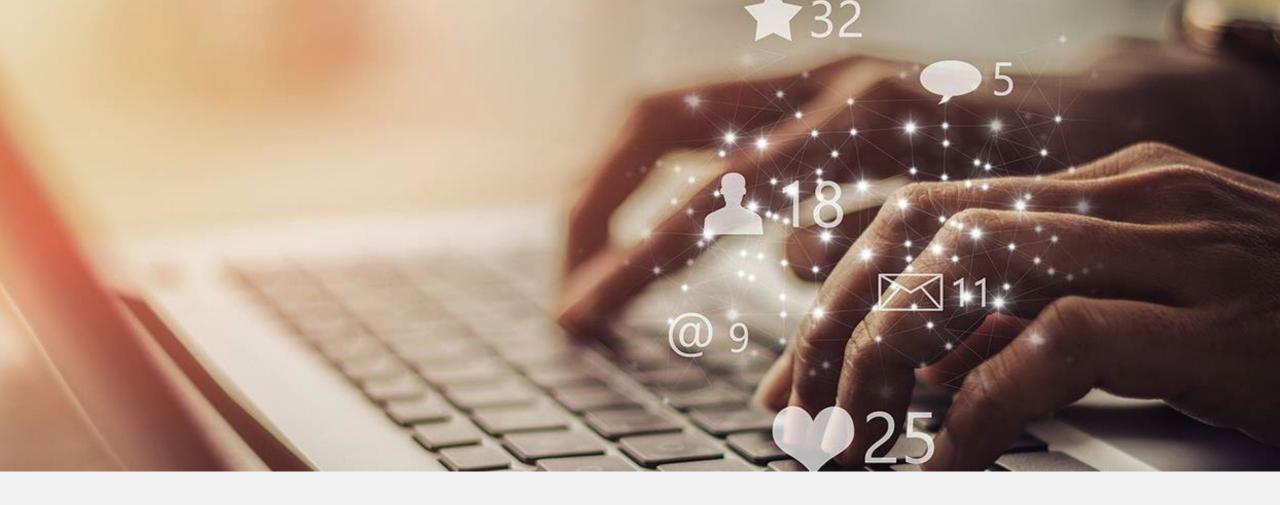
#### Resources and References

- NGS website
  - CMS-1500 Claim Form Completion Instructions
  - Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims
  - <u>Top Claim Errors</u>
- 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! A follow-up email will be sent to attendees with the Medicare University Course Code.







Text NEWS to 37702; Text GAMES to 37702





