



Proper Medicare Part B Claim Submissions

2/27/2024

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Today's Presenters

Provider Outreach and Education Consultants

- Arlene Dunphy, CPC
- Carleen Parker









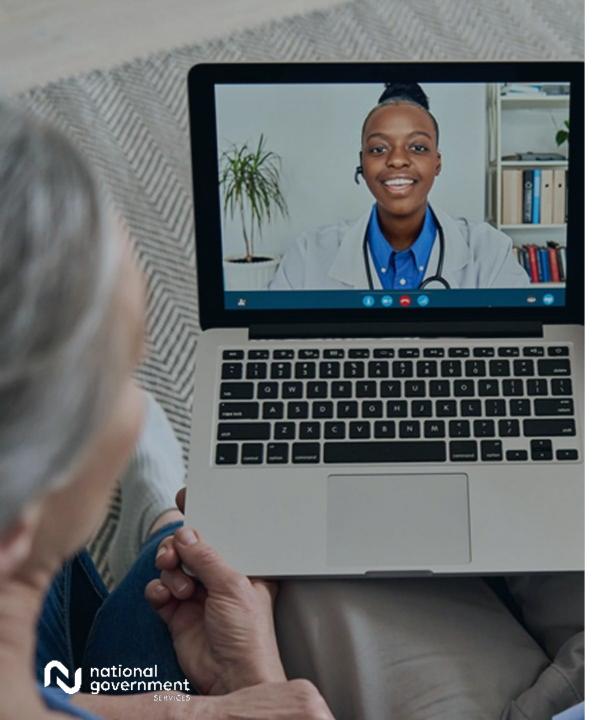


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Recording

 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
- 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
 - \checkmark 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 ٠ 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)

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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

1.	MEDICARE	MEDICAID	TRICARE	CHAMPVA	GROUP	FECA	OTHER
	(Medicare#)	(Medicaid#)	(ID#/DoD#)	(Member ID#)	(ID#)		(ID#)

ſ	ltem No.	Claim Description	Loop	Field	Data Element Description	Requirements	
					SBR09	Claim editing indicator code	Must = MB for Medicare Part B
	1		Primary Payer Responsibility (P = Primary, S = Secondary T = Tertiary				
l				SBR02	Individual Relationship Code	Individual relationship code (18 = Self)	

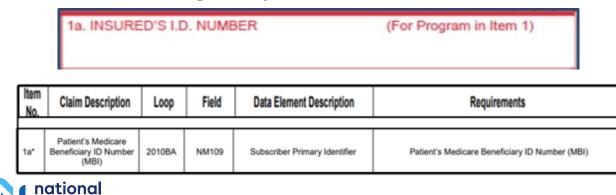


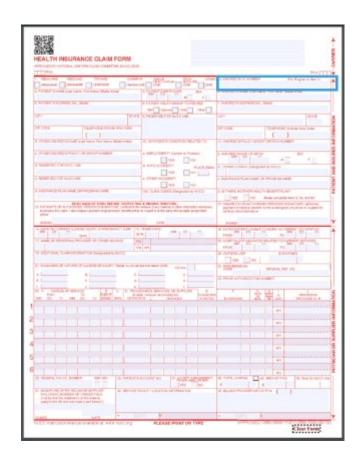


Line Item 1a

- 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

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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)

	Requirements
at's Name or NM103 Last Name Enter the patient's na	
M105 Middle initial	Enter the patient's name as shown on their Medicare card
NN NN	1104 First Name





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

3. PATIEN MM	TH DATE YY	SEX	
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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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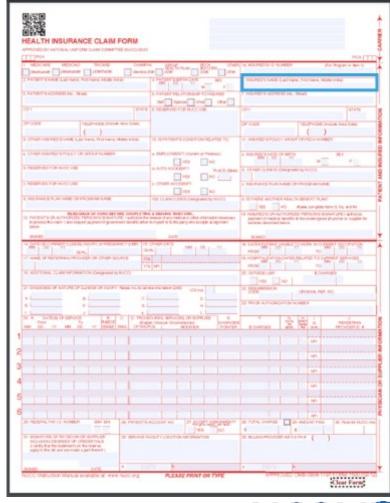




- Name of the insured, if there is insurance primary to Medicare, either through the patient or spouse's employment or any other source
- Enter the word, "same," when insured is same as patient
- When Medicare is secondary payer (MSP), items 4, 6, 7 and 11 are required items

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 primary to Medicare, 2330A	NM103	Other insured last name	Enter the insured's name. Required if any other payers are	
4*		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
	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.



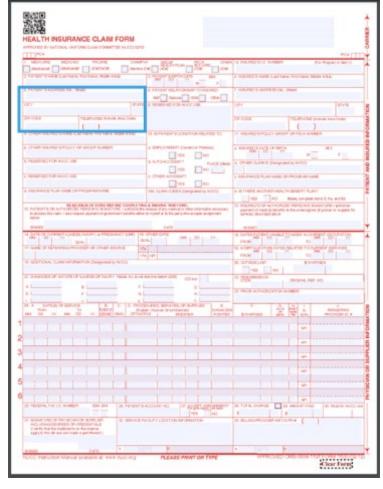




- Patient's street address on first line, city, state on second line and ZIP code and phone number on third line
- For home visits rendered in state other than patients home address, enter in Item 5 the patient's mailing address and line item 32, enter complete address, including ZIP code, where the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

5. PATIENT'S ADDRE	
aty	STATE
ZIP CODE	TELEPHONE (Include Area Code)
	()

lter No		Loop	Field	Data Element Description	Requirements
			N301	Subscriber address line 1	
I 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
I .	terepriorie number		N402	Subscriber state	
			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., 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								
	Insured's address and		N302	Other subscriber address line 2	payers are known to potentially be involved in paying this clain								
7*	(Complete this MSP	2330A	2330A	2330A	2330A	2330A	2330A	2330A	2330A	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								
	(interior)		N403	Other subscriber ZIP code	does not repeat in the 2330A Loop.								

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- Reserved for future NUCC use
- Not mapped electronically

8. RESERVED FOR NUCC USE

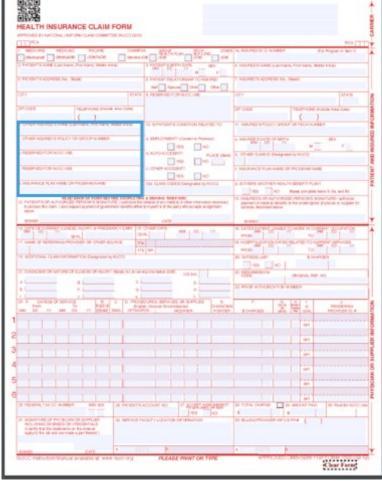




Line Items 9, 9a–9d

- 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

9. OTHER	R INSURED'S NAME (Last Name, First Name, Middle Initial)
a OTHER	INSURED'S POLICY OR GROUP NUMBER
b. RESER	VED FOR NUCC USE
c. RESER	VED FOR NUCC USE
d. INSURA	ANCE PLAN NAME OR PROGRAM NAME





NGSMU

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

ltem 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 Medigop plan
	Middle Initial)		NM105	Other insured middle name	
		2330A	NM108	Identification Code Qualifier (MI Member Identification Number)	Medigap policy ID
	Other insured's policy		NM109	Other insured identifier	Nedgep
Se*	or group number (Medigap only)	2320	58R01	Payer responsibility	P Primary S Secondary T Tertiary
			SBR03	insured group or policy number	Enter the insured's group or plan number
964	Other insured's date of birth and sex		· · · · ·		- -
	Employer's name or		N401	Other payer sity name	Enter the city, state and ZIP code of the insurer. Required if an
86	school name (Medigop	23338	N402	Other payer state code	other payers are known to potentially be involved in paying the claim.
	Address)		N403	Other payer ZIP code	
98*	inevrance plan name or program name	23305	NM198	Other payer identification Code Qualifier	Modigap plan only
			NN109	Payer last or organization name	
			NM103	insured's group/policy no.	1





Line Items 10a, 10b and 10c

EALTH INSURANCE CLAIM FORM			
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- Employment, auto liability, or other accident involvement
- If checked "YES," identify primary insurance and submit to the primary and enter the twoletter state postal code for auto liability

a. EMPLOYMENT? (Curren	t or Previous)
YES	NO
b. AUTO ACCIDENT?	PLACE (State)
YES	NO
c. OTHER ACCIDENT?	
YES	NO

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.





Line Item 10d

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

10d. CLAIM CODES (Designated by NUCC)

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Line Items 11, 11a–11d

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- 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
 - \checkmark 11a-insured eight-digit DOB and sex code
 - ✓ 11b-leave blank
 - ✓ 11c-MSP plan name
 - ✓ 11d-Not required

11. INSURED'S POLICY (GROUP OR FECA NUMBER	
a. INSURED'S DATE O	F BIRTH SEX	
MM DD	YY M F	
b. OTHER CLAIM ID (Des	ignated by NUCC)	
c. INSURANCE PLAN NA	ME OR PROGRAM NAME	
d. IS THERE ANOTHER H	HEALTH BENEFIT PLAN?	
YES NO	If yes, complete items 9, 9a and 9d.	





EMC Equivalent Line 11

tem 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.				and the second sec		
		2320	SBR03	Insured Group or Policy Number						
		2330A	NM108	Identification Code Qualifier (MI Member Identification Number)	If there is an insurance primary to Medicare, enter the Insured's					
			NM109	Insured's identifier						
	[Insurance Type Code						
11*	Insured policy group	2000B or 2320	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"		If there is an insurance primary to Medicare, enter the Insured's	here is an insurance primary to Medicare, enter the Insured's plicy or group number. Required if other payers are known to	E AN		
	or FECA number		CLM01	Claim submitter's identifier	potentially be involved in paying this claim.					
		2300	CLM02	Monetary amount	·····					
			AMT01	Amount qualifier code = D						
		2320	AMT02	Monetary amount (Primary Paid Claim Level)						
		2320 or	CAS01	Claim adjustment reason code (CO, PR. OA)				The second se		
		2320 or 2430	CAS02	Claim adjustment reason codes						
		2100	CAS03	Adjustment amount					A COMPANY	
			CAS04	Adjustment quantity						
		2330B or	DTP01	Primary insurance adjudication date			_	-	-	
		2430	DTP02	Date time period qualifier						
			DTP03	Date paid						





EMC Equivalent Lines 11, 11a–11c

 <u>Electronic Data Interchange: Medicare</u> <u>Secondary Payer ANSI Specifications for 837P</u>

ltern 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- 1	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	_
			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
11c	Insurance plan name or program name	2330B	NM103	Other payer organization name	Enter the complete insurance plan name
	a programmano	2330B	NM109	Other payer primary identifier	Enter the payer ID of the other insurer







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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



ltern No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Patient's or authorized	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	Patients of autonized person's signature (Release of Information)	2320	O106	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.



- 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

ltem No.	Claim Description	Loop	Field	Data Element Description	Requirements
47	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

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)

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





- Not required
- Not mapped electronically

15. OTHER DATE		DD	w
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- 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
10	Dates patient unable to work in current		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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17a.		×		
17b.	NPI			

HEALTH INSURANCE CLAIM FORM					
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EMC Equivalent Lines 17 and 17b

Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
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	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 entry th the rendering provider for this service line. When a claim involves multiple referring and/or ordering physicians, a separ
			NM105	Referring provider middle name	
	Name of Ordering physician		NM103 (DK)	Ordering provider last name	claim must be billed for each ordering/referring 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 NM109. Enter the NPI of the referring/ordering physician listed in
			REF02 (1C)	Ordering provider primary ID	Net 109. Enter the NP1 of the referring/ordering physician listed in Item 17







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 Admission and discharge hospital care codes related to services

18. HOSPITAL	ZATION DATES	RELATED TO CURRE	ENT SERVICES
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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
 - \checkmark Shared post operative care
 - \checkmark Demonstration/clinical trails
 - ✓ Anti-markup/purchased tests
 - ✓ Claim notes

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

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EMC Equivalent Line 19



- Loops 2300/2400/2310D/2320/2420D
 - Segment/fields may differ
- For loops and fields, refer to guide for electronic claims crosswalk
 - <u>Medicare Part B CMS-1500 Crosswalk</u> for 5010 Electronic Claims





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



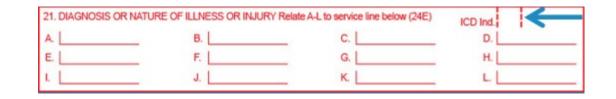
Item No.	Claim Description	Description Loop Field Data Element Description		Data Element Description	Requirements
		2400	PS101	Purchased Service Provider ID	Required if there are diagnostic tests subject to the anti-markup
20	Outside Lab charges	2400	PS102	Purchased Service charge amount	payment price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

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EALTH 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







EMC Equivalent Line 21

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







EALTH INSURANCE CLAIM FORM		
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- Not required
- 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

23, PRIOR AUTHORIZATION NUMBER

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

-== Clear Form

HEALTH INSURANCE CLAIM FOR





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

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HEALTH INSURANCE CLAIM FORM		
APPROVED BY SAFEDIAL UNPORM CLAIM COMMITTEE BIOCO CERT		
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- 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





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

25. FEDERAL TAX LD. NUMBER	SSN EIN
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Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
	Federal Tax ID number REF02		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	

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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.

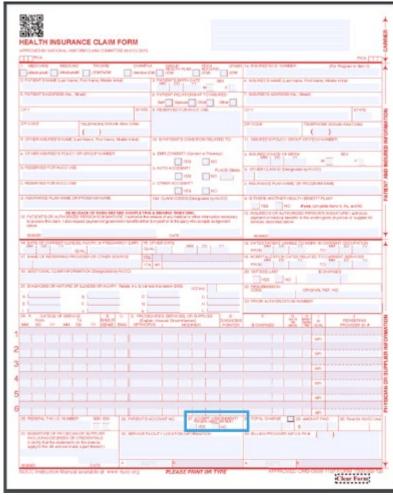
	tem No.	Claim Description	Loop	Field	Data Element Description	Requirements
2	26	Patient's Account number	2300	CLM01	Provider Assigned Account number	Enter the patient's account number assigned by the provider of service's accounting system. As a service, any account number will be returned to you up to 20 characters.



- 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

27. ACCEPT ASSIGNMENT? IFor covt. clams, see back)					
YES	NO M				

ltern No.	Claim Description	Loop	Field	Data Element Description	Requirements
27	Accept Assignment?	2300	CUN17	Assignment or Plan Participation code	A=Assigned B=Assignment accepted on Clinical Lab services only C=Niot assigned





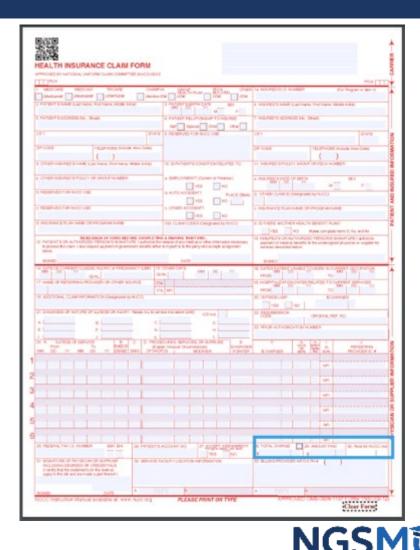


Line Items 28, 29 and 30

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



ltem 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.



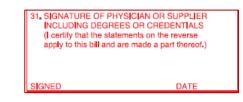


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Paper submitters

- 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



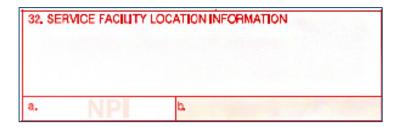
Item No.	Claim Description	Loop	Field	Data Element Description	Requirements
30	Balance due	N301			
31	Signature of physician or supplier including degrees or credentials	2300	CLM06	Provider or supplier signature indicator	Y=Provider signature is on file N=Provider signature is not on file





- 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																	
		2310C	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,																	
			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		Γ						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).		2420C**	2420C**	2420C**	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														
						2420C**	2420C**	2420C**	2420C**	2420C**	2420C**	2420C**	2420C**	2420C**	2420C**	2420C**	2420C**	2420C**	2420C**	N302	Laboratory or Service Facility address 2	were performed. Complete this information for all laboratory performed outside a physician's office. If the service was
							N401	Laboratory or Service Facility city	referred to an outside lab, enter the reference labs name and													
32	32		N402	Laboratory or Service Facility state	address. Providers of service must identify the supplier's name, address and NPI when billing for anti-markup tests. If the																	
			N403	Laboratory or Service Facility ZIP code	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



		23100	NM109 (77)	Laboratory/Facility Primary																		
		24200**	NM109 (77)	klentifier																		
		2400	PS101	Purchased service provider identifier																		
		2420B	NM101	Identification code qualifier =OB	Enter the NDL MARK Design Franks Enter BOOK to be Marked and																	
32a	NPI		NM108	Identification code-XX	Enter the NPI of the Service Facility. Enter "XX" in the NM108 to indicate the NPI is present in the NM109.																	
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EALTH INSURANCE CLAIM FORM	
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- 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 supplier's		NM103 (85)	Provider last or organizational name	NM101 Entity Identifier code=85- Billing Provider
33	billing name, address, zip code & phone	2010AA or 2010AB	NM104 NM105	Provider first name Provider middle initial	NM101 Entity Identifier=87-Pay-to-provider
	number			N301 N401	provider address 1 Provider city
			N402 N403	Provider state Provider ZIP code	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	PER04 NM109 (85)	Provider phone number Provider ID	NM101 Entity Identifier code=85-Billing Provider NM101 Entity Identifier code=85-Billing Provider Enter the NPI for the Group Number of 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.

* = If Medicare Secondary Payer or Medigap is involved, refer to the 5010 TR3.

** = 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
1	Type of Health Insurance	2000B	SBR09	Claim editing indicator code	Must = MB for Medicare Part B
			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
			NM104	First Name	
			NM105	Middle initial	
			NM107	Suffix (e.g., Jr. Sr.)	
3	Patient's Birth Date and gender	2010BA	DMG02	Birth Date	Enter the patient's birth date. Must be formatted as CCYYMMD
			DMG03	Gender	Date qualifier (DMG01) = D8
4*	Insured's name (When there is insurance primary to Medicare, Items 4, 6, 7, and 11 are required items.)	2330A	NM103	Other insured last name	Enter the insured's name. Required if any other payers are known to potentially be involved in paying this claim. If the insured is the patient this would be blank and information reported in the 2010BA Loop does not repeat in the 2330A Loop.
			NM104	Other insured first name	
			NM105	Other insured middle name	





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
 - <u>CMS-1500 Claim Form Completion Instructions</u>
 - 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
 - <u>Chapter 1, General Billing Requirements</u>
 - <u>Chapter 26, Completing and Processing Form CMS-1500</u>





Questions?

Thank you! A follow-up email will be sent to attendees with the Medicare University Course

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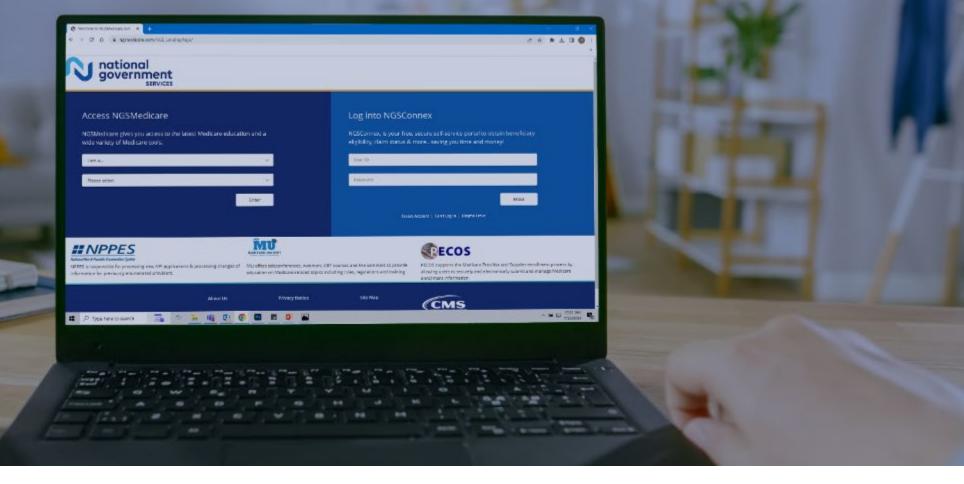


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