DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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Medicare Learning Network®

FACT SHEET

Medicare Billing: 837P and Form CMS-1500

The Hyperlink Table at the end of this document provides the complete URL for each hyperlink.

What are the 837P and Form CMS-1500?

837P: The 837P (Professional) is the standard format used by health care professionals and suppliers to transmit health care claims electronically. Review the chart below "ANSI ASC X12N 837P" for more information about this claim format.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as the Original Medicare).

Form CMS-1500: The Form CMS-1500 is the standard paper claim form that health care professionals and suppliers use to bill Medicare Administrative Contractors (MACs) when a paper claim is allowed. CMS designates the 1500 Health Insurance Claim Form as the CMS-1500 (02/12) and the form is referred to throughout this fact sheet as the CMS-1500.

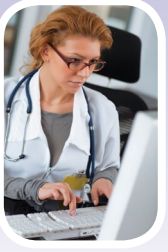
In addition to billing Medicare, the 837P and Form CMS-1500 may be suitable for billing various government and some private insurers. Data elements in the Centers for Medicare & Medicaid Services (CMS) uniform electronic billing specifications are consistent with the hard copy data set to the extent that one processing system can handle both.

ANSI ASC X12N 837P

The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P (Professional) Version 5010A1 is the current electronic claim version. To learn more, visit the ASC X12 website.

ANSI = American National Standards Institute
ASC = Accredited Standards Committee
X12N = Insurance section of ASC X12 for the health insurance industry's administrative transactions
837 = Standard format for transmitting health care claims electronically
P = Professional version of the 837 electronic format
Version 5010A1 = Current version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for health care professionals and suppliers.

The NUCC has developed a crosswalk between the ASC X12N 837P and the hard copy claim form located. MACs may also include a crosswalk on their websites.



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Implementation and Companion Guides for Electronic Transactions

Health care professionals or suppliers billing electronic claims must comply with the ASC X12N implementation guide. The "837P Health Care Claim: Professional" Implementation guide is available for purchase and provides instructions on the content and format requirements for each of the standards' requirements. ASC X12N implementation guides are the specific technical instructions for implementing each of the adopted HIPAA standards and provide instructions on the content and format requirements for each of the standards' requirements. These documents are written for use by all health benefit payers, not specifically for Medicare. Implementation Guides, including Version 5010 Consolidated Guides, can also be purchased from the Washington Publishing Company.

CMS publishes a companion guide to supplement the implementation guide and provide further instruction specific to Medicare. The "5010A1 Part B 837 Companion Guide" provides specific 837P claim loop and segment references. MACs also publish their own companion documents, which provide additional information specific to that contractor's business. To locate a MAC's companion guide, visit that contractor's website.

Please note that the implementation guides and companion guides are technical documents and health care professionals or suppliers may require assistance from software vendors or clearinghouses to interpret and implement the information within the guides.

Medicare Claims Submission

The "Medicare Claims Processing Manual" Internet-Only Manual Publication (IOM Pub.) 100-04 is found on the IOM webpage. This publication includes instructions on claims submission. Chapter 1 includes general billing requirements for various health care professionals and suppliers. Other chapters offer claims submission information specific to a health care professional or supplier type. Once in IOM Pub. 100-04, look for a chapter(s) applicable to your health care professional or supplier type and then search within the chapter for claims submission guidelines. For example, Chapter 20 is entitled "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)."

Refer to Chapter 24 to learn more about electronic filing requirements, including the Electronic Data Interchange (EDI) enrollment form that must be completed prior to submitting Electronic Media Claims (EMCs) or other EDI transactions to Medicare. Refer to Chapter 26 to learn what should be included in the 837P or in each item of the CMS-1500. The "Medicare Benefit Policy Manual" (IOM Pub. 100-02) and the "Medicare National Coverage Determinations (NCD) Manual," (IOM Pub. 100-03) both include coverage information that may be helpful in claims submission. Search for coverage guidance once within a chapter.

Coding

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

Diagnosis Coding

The International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), is currently used to code diagnostic information on claims. You can access ICD-10-CM codes electronically on the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention website or you may purchase hard copy code books from code book publishers.

Procedure Coding

Use Healthcare Common Procedure Coding System (HCPCS) Level I and II codes to code procedures on all claims. Level I Current Procedural Terminology (CPT-4) codes describe medical procedures and professional services. CPT is a numeric coding system maintained by the AMA. The "CPT" code book is available from the AMA Bookstore on the Internet.

The Medicare Learning Network® (MLN) offers a downloadable guide about Evaluation and Management (E/M) codes which are a subset of HCPCS Level I codes. The "Evaluation and Management Services Guide" is available on the CMS website.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and DMEPOS when used outside a physician's office or injections administered within a physician's office or clinic. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the Level II HCPCS codes, or alpha-numeric codes as they may be referred to, were established for submitting claims for these items. These codes are found in the HCPCS code book or by visiting the Alpha-Numeric HCPCS webpage.

Modifiers

Proper use of modifiers with procedure codes is essential to submitting correct claims. The AMA's "CPT" code book includes HCPCS Level I codes and modifiers, while the "HCPCS" code book includes HCPCS Level II codes and related modifiers. Resources about modifiers on the CMS website include:

- The "Modifier 59" article explains the correct use of -59 as a distinct procedural service;
- The Physician Quality Reporting System (PQRS) webpage explains the incentive payment to practices with eligible professionals who satisfactorily report data on their claims;
- The Physician Bonuses webpage outlines whether or not a modifier is required to receive the Health Professional Shortage Area (HPSA) bonus payment; and
- Chapters of the "Medicare Claims Processing Manual" (IOM Pub. 100-04) also offer modifier information. For example, Chapter 30 includes information related to modifiers for Advance Beneficiary Notices (ABNs).

Submitting Accurate Claims

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

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

- Meets a benefit category
- Is not specifically excluded from coverage
- Is reasonable and necessary

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

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

It is a crime to defraud the Federal government and its programs. Punishment may involve imprisonment, significant fines, or both under a number of laws including the False Claims Act, the Anti-Kickback Statute, the Physician Self- Referral Law (Stark Law), and the Criminal Health Care Fraud Statute.

For more information about Medicare Program integrity functions and how health care professionals and suppliers can help to protect Medicare from fraud and abuse, reference the "Medicare Program Integrity Manual" (IOM Pub. 100-08, Chapter 4). The MLN also provides a fact sheet titled "Medicare Fraud & Abuse: Prevention, Detection, and Reporting." This fact sheet is designed to provide education on preventing, detecting, and reporting Medicare fraud and abuse. It includes definitions as well as information on laws, partnerships with other organizations, and resources for additional information.

The MLN also provides a number of compliance education products designed to help health care professionals and suppliers submit accurate claims.

When Does Medicare Accept a Form CMS-1500?

Initial claims for payment under Medicare must be submitted electronically unless a health care professional or supplier qualifies for a waiver or exception from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims.

ASCA Exceptions: Before submitting a hard copy claim on the Form CMS-1500, health care professionals and suppliers are required to self-assess to determine whether they meet one or more of the ASCA exceptions. For example, health care professionals and suppliers that have fewer than10 Full-Time Equivalent (FTE) employees and bill a MAC are considered to be small and might therefore qualify to be exempt from Medicare electronic billing requirements. If a health care professional or supplier meets an exception, there is no need to submit a waiver request.

Waiver Requests: There are other situations when the ASCA electronic billing requirement could be waived for some or all claims, such as if disability of all members of a health care professional's or supplier's staff prevents use of a computer for electronic submission of claims. Health care professionals and suppliers must obtain Medicare pre-approval to submit paper claims in these situations by submitting a waiver request to their MAC.

Refer to Chapter 24, Sections 90-90.6, of the "Medicare Claims Processing Manual" (IOM Pub. 100-04) for further information on ASCA electronic billing requirements and enforcement reviews of health care professionals and suppliers.

Download a sample of the Form CMS-1500 by visiting the CMS Forms List webpage. In the Filter On box, enter 1500. Copies of the CMS-1500 should not be downloaded for submission of claims, since they may not accurately replicate colors included in the form. These colors are needed to enable automated reading of information on the form. Visit the U.S. Government Bookstore to order the form. The CMS-1500 is also available from printing companies and office supply stores; as long as it follows the CMS approved specifications found in the "Medicare Claims Processing Manual" (IOM Pub. 100-04, Chapter 26, Section 30).

Timely Filing

Medicare claims must be filed to the appropriate MAC no later than 12 months, or one calendar year, after the date of service.

Medicare will deny claims if they arrive after the deadline date. When a claim is denied for having been filed after the timely filing period, such a denial does not constitute an initial determination. As such, the determination that a claim was not filed timely is not subject to appeal.

Medicare uses the line item 'From' date to determine the date of service for claims filing timeliness for claims submitted by health care professionals and suppliers that include span dates of service. (This includes Durable Medical Equipment (DME) supplies and rental items.) If a line item 'From' date is not timely but the 'To' date is timely, contractors must split the line item and deny the untimely services as not timely filed.

Medicare regulations allow exceptions to the 12-month time limit for filing claims. To review these exceptions, refer to the "Medicare Claims Processing Manual" (IOM Pub. 100-04, Chapter 1).

Where to Submit FFS Claims

For beneficiaries enrolled in Original (Fee-For-Service) Medicare, health care professionals or suppliers submit claims for services to the appropriate MAC. Contact your Medicare Administrative Contractor (MAC) if you have questions about the Medicare Program. Medicare beneficiaries cannot be charged for completing or filing a claim. Health care professionals and suppliers may be subject to penalty for violations.

For beneficiaries enrolled in a Medicare Advantage (MA) Plan, health care professionals or suppliers should submit claims to the beneficiary's MA Plan. CMS provides a list of MA claims processing contacts.

Medicare Secondary Payer (MSP)

MSP provisions apply to situations when Medicare is not the beneficiary's primary health insurance coverage and ensure that Medicare does not pay for services and items that certain other health insurance or coverage is primarily responsible for paying. For more information, reference the "Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff" fact sheet available through the "MLN Catalog" on the CMS website. The Medicare Secondary Payer webpage offers information on MSP laws and the various methods employed by CMS to gather data on other insurance that may be primary to Medicare.

Resources

This chart provides resources for the "Medicare Billing: 837P and Form CMS-1500" fact sheet.

For more information about	Resources
WEBPAGES	
Electronic Billing & EDI Transactions To read more about submission of electronic claims, visit the CMS Electronic Billing & EDI Transactions webpage.	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html
Health Care Payment and Remittance Advice MACs use a notice called a Remittance Advice (RA) as a means to communicate to health care professionals and suppliers claim processing decisions such as payments, adjustments, and denials. The Health Care Payment and Remittance Advice webpage offers information on the 835 standard transaction for the Electronic Remit Advice (ERA) and the Standard Paper Remit (SPR).	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html
HIPAA Versions 5010 and D.0 & 3.0 This section of the CMS website contains information and educational resources pertaining to Version 5010, which is the version of the X12 standards for HIPAA transactions.	https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/Versions5010andD0/index.html
National Correct Coding Initiative Edits This webpage offers information on NCCI edits for physician and hospital outpatient claims and Medically Unlikely Edits (MUEs).	https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
Professional Paper Claim Form (CMS-1500) This webpage contains information about submitting paper claims. Click on Administrative Simplification Compliance Act Self-Assessment in the left column to read about the limited circumstances when an initial claim may be a paper claim.	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html

For more information about	Resources
WEB-BASED TRAINING (WBT) COURSES	
"837P and Form CMS-1500" Learn about professional Medicare claims requirements; the essential aspects of paper and electronic claims submission; and Medicare claims processing actions.	https://learner.mlnlms.com
"Health Insurance Portability and Accountability Act (HIPAA) EDI Standards" Learn about standards and code sets mandated under HIPAA; information regarding electronic billing and other health care transactions; and the steps involved in the Medicare electronic data interchange process.	https://learner.mlnlms.com
"Medicare Billing Certificate Program for Part B Providers" Learn about Part B of the Medicare Program; Medicare claims; and billing requirements.	https://learner.mlnlms.com
"Medicare Secondary Payer Provisions" Learn about the Medicare Secondary Payer (MSP) provisions; recognize when Medicare is a primary or secondary payer; and how to find CMS MSP resources.	https://learner.mlnlms.com
INTERNET-ONLY MANUAL	
"Medicare Claims Processing Manual," IOM Pub. 100-04, Chapter 26, "Completing and Processing the Form CMS-1500 Data Set" Chapter 26 outlines billing requirements for health care professionals and suppliers using the 837P or Form CMS-1500.	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf
GUIDES	
"Evaluation and Management Services" Learn about medical record; evaluation and management billing and coding considerations; and the "1995 Documentation Guidelines for Evaluation and Management Services" and the "1997 Documentation Guidelines for Evaluation and Management Services."	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html
"MLN Guided Pathways: Provider Specific Medicare Resources" This advanced curriculum includes specialty and facility specific information for Medicare institutional providers physicians, health care professionals, and suppliers.	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN903543.html

For more information about	Resources
BOOKLETS	
"How to Use the National Correct Coding Initiative (NCCI) Tools" Learn about navigating the CMS NCCI webpages, Medicare code pair edits; medically unlikely edits; and avoiding coding and billing errors.	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243274.html
"Medicare Claim Review Programs" Learn about different CMS claim review programs; coverage and coding errors; and how to assist providers in reducing payment errors.	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243290.html
"NPI: What You Need to Know" This booklet is designed to provide education on the National Provider Identifier (NPI). It includes information on NPI basics, the National Plan and Provider Enumeration System, health care provider categories, and how to apply for an NPI.	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1232538.html
OTHER MLN PRODUCTS	
"Medicare Learning Network® (MLN) Suite of Products & Resources for Billers and Coders" Learn about claims submission; Federal initiatives and incentive programs; and more.	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/ICN904183.html
"New Maximum Period for the Submission of Medicare Claims Podcast" This podcast is designed to provide education on the new maximum period that providers have for the submission of Medicare Claims. It includes information to determine the date of service on the claim statement.	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia-Items/CMS1242093.html

Hyperlink Table

Embedded Hyperlinks	Complete URLs
ASC X12 website	http://www.x12.org/
National Uniform Claim Committee (NUCC)	http://www.nucc.org/
NUCC Crosswalk	http://www.nucc.org/images/stories/PDF/1500_form_map_to_837p_5010_v2-0_112011.pdf
"837-P Health Care Claim: Professional Implementation Guides"	http://store.x12.org/store/healthcare-5010-original-guides
Washington Publishing Company	http://www.wpc-edi.com/
"5010A1 Part B 837 Companion Guide"	https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/CompanionGuides.html
Internet Only Manuals (IOM)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
Medicare Claims Processing Manual Chapter 1 General Billing Requirements	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf
Medicare Claims Processing Manual Chapter 20 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf

Embedded Hyperlinks	Complete URLs
Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Medicare Claims Processing Manual Chapter 24 – General EDI and EDI Support Requirements, Electronic Claims, and Mandatory Electronic Filing of Medicare Claims	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c24.pdf
Medicare Claims Processing Manual Chapter 26 - Completing and Processing Form CMS-1500 Data Set	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf
Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf
Medicare Benefit Policy Manual (IOM Pub. 100-02)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS012673.html
“Medicare National Coverage Determinations (NCD) Manual” (IOM Pub. 100-03)	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS014961.html
Centers for Disease Control and Prevention website	http://www.cdc.gov/nchs/icd/icd10cm.htm
AMA Bookstore	https://commerce.ama-assn.org/store/
“Evaluation and Management Services Guide”	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html
Alpha-Numeric HCPCS	https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html
“Modifier 59”	https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf
Physician Quality Reporting System (PQRS)	https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
Physician Bonuses	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses/index.html
Medicare Program Integrity Manual Chapter 4 - Program Integrity	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c04.pdf
“Medicare Fraud & Abuse: Prevention, Detection, and Reporting”	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243333.html
Provider Compliance Education Products	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
CMS Forms List	https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html
U.S. Government Bookstore	http://bookstore.gpo.gov/
Contact your Medicare Administrative Contractor (MAC)	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

Embedded Hyperlinks	Complete URLs
Medicare Advantage (MA) Claims Processing Contacts	https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-Claims-Processing-Contacts.html
"Medicare Secondary Payer for Providers, Physicians, and Other Suppliers, Billing Staff"	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243357.html
Medicare Secondary Payer	https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer.html

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