MEDICARE BILLING:
FORM CMS-1500 AND THE 837 PROFESSIONAL

> Note: No substantive content updates.

INTRODUCTION

This booklet offers education for health care administrators, medical coders, billing and claims processing personnel, and other medical administrative staff who are responsible for submitting Medicare professional and supplier claims for Medicare payment using the 837P or Form CMS-1500.

Note: The term "patient" refers to a Medicare beneficiary.

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 for the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P for more information.

Form CMS-1500
Through the provisions of the Administrative Simplification Compliance Act (ASCA), CMS permits its physicians/practitioners and suppliers to submit a CMS-1500 under certain situations. Centers for Medicare & Medicaid Services (CMS) names the 1500 Health Insurance Claim Form as the CMS-1500 (02/12) and we call the form the CMS-1500 throughout this booklet.

In addition to billing Medicare, the 837P and Form CMS-1500 are sometimes suitable for billing various government and some private insurers. Data elements in the 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 ANSI 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

The National Uniform Claim Committee (NUCC) developed a crosswalk between the ASC X12N
837P and the hard copy claim form. MACs may also include a crosswalk on their websites.

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
has 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 give instructions on the content and format requirements for each of the standards'
requirements. ASC X12N writes these documents for all health benefit payers, not specifically for Medicare.
You can purchase Implementation Guides, including Consolidated Guides from the Washington Publishing
Company by contacting them at 425-562-2245.

Each MAC publishes a CMS approved Medicare Fee-For-Service (FFS) HIPAA 837P Companion Guide (CG).
The CG clarifies, supplements, and further defines specific Medicare FFS data content requirements to be
used with, but not in place of, the HIPAA 837P. Each MAC's CG is specific to that MAC. Review the 5010A1
Part B 837 Companion Guide page to locate your specific MAC's CG.

Implementation guides and companion guides are technical documents and health care professionals or
suppliers may require help from software vendors or clearinghouses to interpret and implement the information
within the guides.

MEDICARE CLAIMS SUBMISSIONS

The Medicare Claims Processing Manual (Internet-Only Manual [IOM] Pub. 100-04) includes instructions on
claim 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 the
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

Visit Chapter 24 to learn more about electronic filing requirements, including the Electronic Data Interchange
(EDI) form that CMS requires before submitting Electronic Claims . Refer to Chapter 26 to learn what each
claim must include in the 837P or in each field 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 helpful in claims submission. Search for coverage guidance once within a
chapter.

Refer to the MSP Manual found in IOM Pub. 100-05, which provides direction on MSP policies, procedures, MSP claims and MSP payments.

CODING

Correct coding is key when submitting valid claims. Use current valid diagnosis and procedure codes and code the claims to the highest level of specificity (maximum number of digits) available to ensure claims are as accurate as possible. The Medicare Claim Processing Manual Chapter 23 is the 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 used to code diagnostic information on claims. Visit the Centers for Disease Control and Prevention website to access ICD-10-CM codes electronically 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 American Medical Association (AMA). Visit the AMA Bookstore to purchase the CPT code book.

The Medicare Learning Network® (MLN) has an Evaluation and Management (E/M) codes guide. These codes are a subset of HCPCS Level I codes.

Level II of the HCPCS is a standardized coding system 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 aren't identified by CPT codes, the Level II HCPCS codes, also known as the alpha-numeric codes, were established by CMS for submitting claims for these items. To view these codes, review the HCPCS code book or visit the Alpha-Numeric HCPCS webpage.

SUBMITTING ACCURATE CLAIMS

Health care professionals and suppliers play a vital role in protecting the integrity of the Medicare Program. They submit accurate claims, maintain current knowledge of Medicare billing policies, and ensure all documentation the MAC requires to support the medical need for the service rendered is submitted when requested.

Modifiers

Use proper modifiers with procedure codes to submit 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 include:

- The Modifier 59 article which explains the correct use of -59 as a distinct procedural service.

- The Physician Bonuses webpage outlines whether or not a modifier is required to get the Health Professional Shortage Area (HPSA) bonus payment.

- Medicare Claims Processing Manual (IOM Pub. 100-04) chapters which also offer modifierinformation. For example, Chapter 30 includes information related to modifiers for Advance Beneficiary Notices (ABNs).

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

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

In general, **fraud** is defined as making false statements or representations of material facts to get 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's 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 protect Medicare from fraud and abuse, refer to the Medicare Program Integrity Manual (IOM Pub. 100-08, Chapter 4). The MLN also offers a booklet the Medicare Fraud & Abuse: Prevent, Detect, and Report Booklet. Learn about the fraud and abuse definitions; laws used to fight fraud and abuse; government partnerships engaged in fighting fraud and abuse; and where to report suspected fraud and abuse.

The MLN also has provider compliance education products to help health care professionals and suppliers submit accurate claims.

WHEN DOES MEDICARE ACCEPT A FORM CMS-1500?

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

ASCA Exceptions
Before submitting a hard copy claim on the Form CMS-1500, health care professionals and suppliers must self-assess to determine whether they meet one or more of the ASCA exceptions. For example, CMS considers health care professionals and suppliers that have fewer than 10 Full-Time Equivalent (FTE) employees and bill a MAC to be small and might qualify to be exempt from Medicare electronic billing requirements. If a health care professional or supplier meets an exception, they don't need to submit a waiver request.

Waiver Requests
CMS may also waive the ASCA electronic billing requirement in certain other situations 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.
To learn more about the ASCA waivers and exceptions, visit the Electronic Billing & EDI Transactions webpage and go to the left menu to select one of the ASCA options. 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 aren't usable 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 at printing companies and office supply stores.

TIMELY FILING

Providers must file Medicare claims to the proper MAC no later than 12 months, or 1 calendar year, after the date of service.

Medicare will deny claims if they arrive after the deadline date. When Medicare denies a claim for filing after the timely filing period, such a denial doesn't mean the same thing as an initial determination. The determination that a claim wasn't filed timely isn't subject to appeal.

Medicare uses the line item 'From' date to determine the date of service for claims filing timeliness regarding 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 isn't 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 patients enrolled in Original Fee-For-Service (FFS) Medicare, health care professionals or suppliers may submit claims for services to the proper MAC. Contact your MAC if you have questions. Medicare beneficiaries can't be charged for completing or filing a claim. Providers may be subject to penalty for violations.

For patients enrolled in a Medicare Advantage (MA) Plan, health care professionals or suppliers should submit claims to the patient's MA Plan. CMS has a list of MA Claims Processing Contacts.

Medicare Secondary Payer (MSP)
MSP provisions apply to situations when Medicare isn't the patient's primary health insurance coverage. MSP provisions ensure Medicare doesn't pay for services and items that pertain to other health insurance or coverage that's primarily responsible for paying. For more information, refer to the Medicare Secondary Payer Booklet and the Medicare Secondary Payer Provisions Web-based Training (WBT) course. The Medicare Secondary Payer webpage offers information on MSP laws and the various ways CMS gathers data on other insurance that may be primary to Medicare offers information on MSP laws and the various methods CMS gathers data on other insurance potentially primary to Medicare.

KEY TAKEAWAYS

- The 837P is the standard format used by health care professionals and suppliers to transmit health care claims electronically. The Form CMS-1500 is the standard claim form to bill MACs when a paper claim is allowed.

- The ANSI X12N 837P (Professional) Version 5010A1 is the current electronic claim version. The National Uniform Claim Committee (NUCC) developed a crosswalk between the ASC X12N 837P and the hard copy claim form.

- ASC X12N publishes implementation guides that are the specific technical instructions for implementing each of the adopted HIPAA standards. Purchase implementation guides, including Version 5010 consolidated guides, at the ASC X12 store or from the [Washington Publishing Company](). [Contact your MAC]() for the associated CMS implementation guides.

- The Medicare Claims Processing Manual (Internet-Only Manual Publication [IOM Pub.] 100-04) includes instructions on claims submission.

- Correct coding is key to submitting valid claims. Use current valid diagnosis (ICD-10-CM) and procedure (HCPCS Level I and II codes and Level I CPT-4) codes, and code to the highest level of specificity (maximum number of digits).

- Medicare coverage and payment depends on a determination that an item or service meets a benefit category, isn't specifically excluded from coverage, and is reasonable and necessary

- Providers play a critical role in preventing Medicare fraud and abuse. CMS offers a number of resources to providers about fraud and abuse.

- Providers must submit Medicare initial claims electronically unless the provider qualifies for a waiver or exception under the ASCA.

- Providers must file Medicare claims to the proper MAC no later than 12 months, or 1 calendar year, after the date of service. Medicare will deny claims not filed on time.

RESOURCES

- [5010A1 Part B 837 Companion Guide]()
- [Alpha-Numeric HCPCS]()
- [AMA Bookstore]()
- [ASC X12 837-P Health Care Claim: Professional Implementation Guides]()
- [CDC]()
- [CMS Forms List]()
- [Evaluation and Management Services Guide]()
- [IOMs (including Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, MSP Manual, and NCD Manual)]()
- [MAC Website List]()
- [MA Claims Processing Contacts]()
- [Medicare Fraud & Abuse: Prevent, Detect, and Report Booklet]()
- [MSP Booklet]()
- [MSP WBT]()
- [MSP Webpage]()
- [Modifier 59 Article]()
- [NUCC Crosswalk]()
- [Physician Bonuses Webpage]()

- [Provider Compliance Education Products](#)
- [U.S. Government Bookstore](#)
- [Washington Publishing Company](#)

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