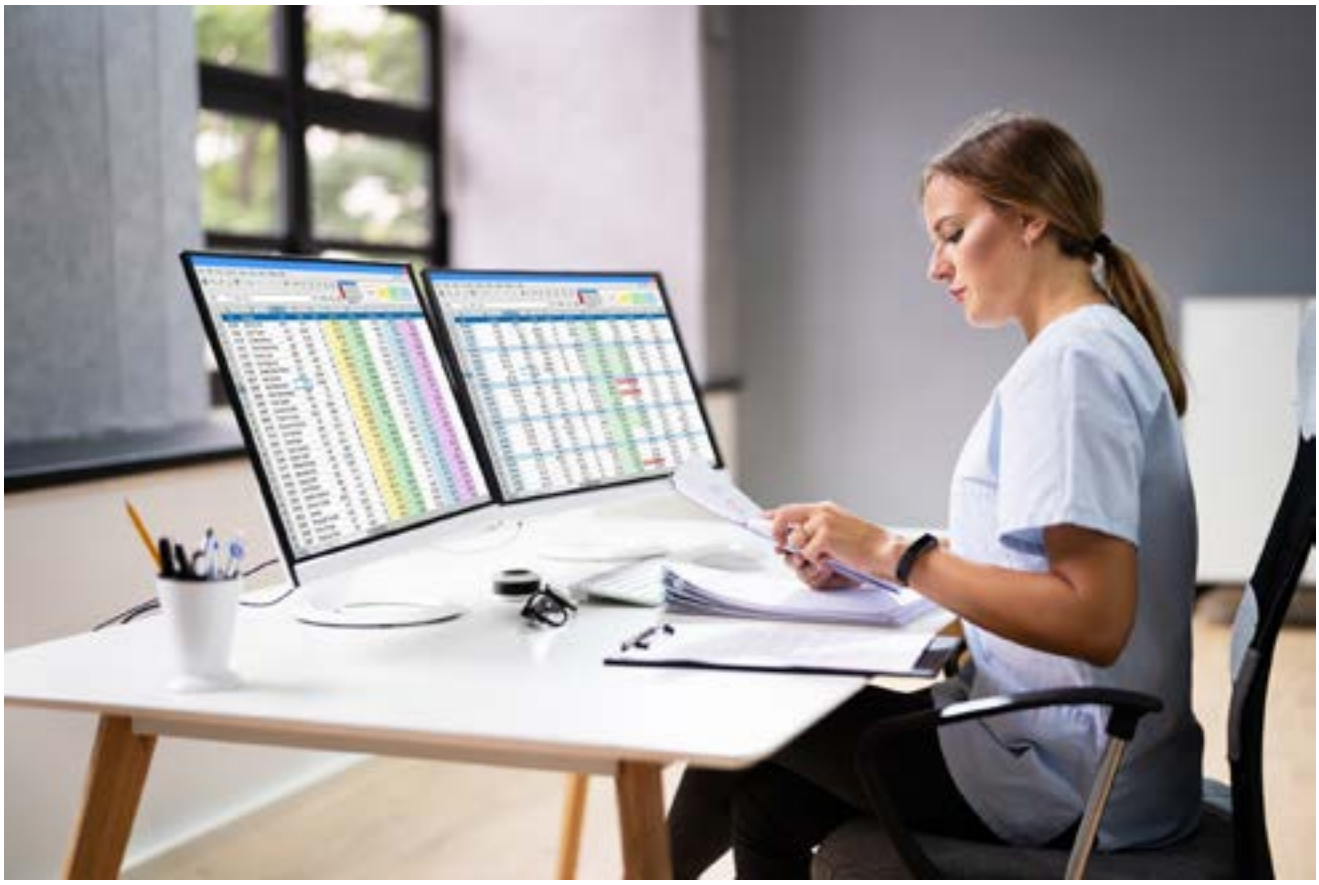
mln Booklet

KNOWLEDGE • RESOURCES • TRAINING

Medicare Billing: CMS-1450 & 837I



What's Changed?

Note: No substantive content updates.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

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This booklet offers education for health care administrators, medical coders, billing and claims processing personnel, and other medical administrative staff who submit Medicare provider claims using the **837I (Institutional)** and **Form CMS-1450**.

Note: The term patient refers to a Medicare beneficiary.

What are the Form CMS-1450 & the 837I?

Form CMS-1450

When CMS allows a paper claim, the Form CMS-1450, also known as the UB-04, is the standard claim form to bill Medicare Administrative Contractors (MACs). CMS allows providers to submit a paper claim if they meet the Administrative Simplification Compliance Act (ASCA) exceptions.

Sometimes providers use the CMS-1450 and 837I to bill certain government and private insurers. We make data elements in the hard copy data set consistent with the uniform electronic billing specifications to the extent that 1 processing system can handle both.

837I

The 837I is the standard format institutional providers use to submit health care claims electronically.

Institutional providers include:

- Community Mental Health Centers (CMHCs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Critical Access Hospitals (CAHs)
- ESRD providers
- Federally Qualified Health Centers (FQHCs)
- Histocompatibility laboratories
- Home Health Agencies (HHAs)
- Hospice organizations
- Hospitals
- Indian Health Service (IHS) Facilities
- Opioid Treatment Programs (OTPs)
- Organ Procurement Organizations
- Outpatient Physical Therapy (OPT)/ Occupational Therapy (OT)/Speech-Language Pathology (SLP) Services
- Religious non-medical health care institutions (RNHCIs)
- Rural Emergency Hospitals (REHs)
- Rural health clinics (RHCs)
- Skilled nursing facilities (SNFs)

ANSI ASC X12N 837I

The ANSI ASC X12N 837I Version 5010A2 is the current electronic claim version. Find more information on the ASC X12 website.

ANSI ASC X12N 837I 5010A2: Key Terms

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

I: Institutional version of the 837 electronic format

Version 5010A2: Current version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for institutional providers

The National Uniform Billing Committee (NUBC) offers their UB-04 manual through its website. This manual has the updated specifications for the data elements and codes included on the CMS-1450 and used in the 837I transaction standard. MACs may include a crosswalk between the ASC X12N 837I and the CMS-1450 on their websites.

Electronic Transactions Implementation & Companion Guides

Providers billing electronic claims must comply with the ASC X12N implementation guide. The 837I Health Care Claim: Institutional Implementation Guide is available from X12 by purchasing an X12 License. Visit the X12 licensing webpage to learn more.

ASC X12N implementation guides are specific technical instructions for carrying out each adopted HIPAA standard and have instructions on content and format requirements for each standard's requirements. ASC X12N writes these documents for all health benefit payers.

Each MAC publishes a CMS-approved companion guide to supplement the implementation guide that offers further Medicare instructions. The 5010A2 - Part A 837 Companion Guide (CG) offers specific 837I electronic claim loop and segment references.

Find your MAC's website or review the Medicare Fee-for-Service Companion Guides webpage to locate your MAC's CG.

Implementation and companion guides are technical documents, and you may need help from billing agencies, clearinghouses, or software vendors to interpret and implement the information.

Submitting Medicare Claims

The Medicare Claims Processing Manual has instructions on how to submit claims:

- Chapter 1 has general billing requirements
- Chapter 10 has home health billing guidelines
- Chapter 24 explains electronic filing requirements and the required Electronic Data Interchange (EDI) form before submitting electronic claims
- Chapter 25 explains what each claim must include

The Medicare Benefit Policy Manual and the Medicare National Coverage Determinations (NCD) Manual include helpful submitting claims coverage information.

Refer to the Medicare Secondary Payer Manual (MSP) for direction on MSP policies, procedures, claims, and payments.

Coding

Correct coding is important when submitting valid claims. Use current diagnosis and procedure codes and code to the highest level of specificity. Use the greatest number of digits available to make sure claims are as accurate as possible. The Medicare Claims Processing Manual, Chapter 23, has information on diagnosis coding, procedure coding, and instructions for codes with modifiers.

Diagnosis Coding

Use ICD-10-CM to code diagnostic information. Multiple entities publish ICD-10-CM manuals. The CDC website has access to ICD-10-CM codes electronically, or you can buy hard copy code books from code book publishers.

Procedure Coding

Use HCPCS Level I and II codes to code all claim procedures, except for inpatient hospitals. Use ICD-10-PCS codes for procedure coding on inpatient hospital Part A claims.

Level I CPT-4 codes describe medical procedures and professional services. CPT's a numeric coding system the American Medical Association (AMA) maintains. Get the CPT code book at the AMA Store.

The Medicare Learning Network® has an Evaluation and Management Services Guide that offers helpful information about the HCPCS Level I codes subset.

HCPCS Level II is a standardized coding system used primarily to name products, supplies, and services not included in the CPT codes like ambulance services and DMEPOS. To view these codes, review the HCPCS codebook or visit the Alpha-Numeric HCPCS webpage.

National Uniform Billing Committee (NUBC) Codes

The 837I and CMS-1450 also require codes maintained by the NUBC, including:

- Condition codes
- Discharge status
- Occurrence codes
- Occurrence Span Codes
- Point of Origin
- Revenue codes
- Type of Bill
- Type of Visit
- Value codes

More information is available to subscribers of the NUBC Official UB-04 Data Specifications Manual. To subscribe, go to the NUBC website.

Submitting Accurate Claims

Providers can protect the Medicare Program's integrity by:

- Keeping up to date on Medicare billing policies
- Submitting accurate claims
- Submitting all MAC-required documentation to support the medical need for services

Modifiers

Use proper modifiers with procedure codes to submit accurate claims. The AMA's CPT code book includes HCPCS Level I codes and modifiers. The HCPCS code book includes HCPCS Level II codes and related modifiers. Resources about modifiers:

- Proper Use of Modifiers 59, XE, XP, XS, & XU fact sheet explains correct use of these modifiers.
- Medicare Claims Processing Manual offers modifier information. For example, Chapter 30 includes information on modifiers for Advance Beneficiary Notices (ABNs).
- Medicare National Correct Coding Initiative Policy Manual, Chapter 1, Section E, offers detailed information on using modifiers.

Medicare coverage and payment require that an item or service:

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

Fraud, Waste, & Abuse

In general, we define **fraud** as making false statements or representations of material facts to get some help or payment for which no entitlement would otherwise exist.

Waste describes practices that, directly or indirectly, result in unnecessary Medicare Program costs, like overusing services. Waste is generally not considered to be criminally negligent but rather the misuse of resources.

Abuse describes practices that directly or indirectly result in unnecessary costs to the Medicare Program. Abuse includes any practice that doesn't provide patients with medically necessary services or meet professionally recognized standards of care.

It's a crime to defraud the federal government and its programs. Punishment may include imprisonment, significant fines, or both under some laws, including the False Claims Act, the Anti-Kickback Statute, the Physician Self-Referral Law (commonly referred to as the "Stark Law"), and the Criminal Health Care Fraud Statute.

For more information about Medicare Program integrity functions and how you can help protect Medicare from fraud, waste and abuse, refer to the Medicare Program Integrity Manual, Chapter 4. Learn about fraud and abuse definitions, laws used to fight fraud and abuse, government partnerships fighting fraud and abuse, and where to report suspected fraud and abuse in the Medicare Fraud & Abuse: Prevent, Detect, Report booklet.

The MLN also offers compliance education products to help institutional providers submit accurate claims.

Electronic Filing Exceptions & Waivers

Providers must submit Medicare initial claims electronically unless they qualify for a waiver or exception under the Administrative Simplification Compliance Act (ASCA).

ASCA Exceptions

Before submitting a hard copy claim on the CMS-1450, determine if it meets 1 or more ASCA exceptions. Medicare exempts health care provider billing when you:

- Have fewer than 25 full-time equivalent employees (FTEs) and bill a MAC
- Roster bill, which allows mass immunizers to complete 1 CMS-1450 with the flu or pneumonia shot and attach a roster listing patients who got that shot, rather than submitting separate CMS-1450 claim forms
- Submit paper claims under a Medicare demonstration project
- Submit MSP claims when there's more than 1 primary payer and more than 1 allowed amount, including more than 1 contractual obligation amount, as applicable

If you meet an exception, you don't need to submit a waiver request. Health care providers who submit paper claims exception justification to their MAC are either:

- Notified of approval by mail
- Notified exception wasn't approved

If health care providers don't respond to a request for exception information, CMS will deny their paper claims, effective the 91st calendar day after the first letter date asking for documentation.

You can't appeal these decisions.

Waiver Requests

These Unusual Circumstance Waivers are subject to provider self-assessment and always meet waiver criteria:

- Dental claims
- Electricity, phone or communication disruption expected to last longer than 2 business days
- Large group practice or supplier that submits less than 10 claims a month and not more than 120 claims per year

Unusual Circumstance Waivers require Medicare pre-approval to submit paper claims in these situations:

- Provider alleges HIPAA claim transaction implementation guides don't support electronic submission of all data needed for claim adjudication
- Provider isn't small, but all employees have documented disabilities that prevent them from using personal computers for electronic claim submission
- Any other unusual situation documented by a provider to prove that enforcing electronic claim submission requirements is against equity and good conscience

Find more information about ASCA waivers and exceptions on the Electronic Billing & EDI Transactions webpage.

Find more information on ASCA electronic billing requirements and enforcement reviews in the Medicare Claims Processing Manual, Chapter 24, Sections 90-90.6.

CMS doesn't supply the CMS-1450 to providers for claim submission. Don't download a copy of the form to submit claims because your copy may not accurately replicate form colors. The system needs these colors for automated form reading. Visit the U.S. Government Bookstore to order the form, or contact local printing companies or office supply stores to get them.

You can find Medicare CMS-1450 UB-04 completion and coding instructions in the Medicare Claims Processing Manual, Chapter 25.

Time Limits for Filing Claims

Medicare claims must be filed with the correct MAC no later than 1 calendar year after the date of service. In general, the start date for determining the 1 calendar year timely filing period is the date of service or "From" and "Through" date on the claim.

Claims will be rejected if you file them after the deadline. When a claim is denied for timely filing, it's not the same thing as an initial determination. As such, the determination that a claim wasn't filed timely can't be appealed for payment.

There are limited exceptions to the 1 calendar year timely filing deadline. For more information, see sections 70, et al. of the Medicare Claims Processing Manual, Chapter 1.

Where to Submit Claims

For patients enrolled in Original Fee-for-Service (FFS) Medicare, submit claims for services to the appropriate MAC. Find your MAC's website if you have questions.

You can't charge patients for completing or filing a claim. We subject providers to penalties for violations.

For patients enrolled in a Medicare Advantage (MA) plan, submit claims to the patient's MA Plan, unless otherwise directed.

Medicare Secondary Payer (MSP)

For patients with primary coverage other than Medicare, also known as Medicare Secondary Payer (MSP), you must bill the correct primary insurer first. Find information in the Medicare Secondary Payer booklet, the Medicare Secondary Payer Manual, and the Medicare Secondary Payer webpage.

Resources

- CMS-1450 form
- HIPAA and Administrative Simplification webpage
- Medicare Billing 837I & Form CMS-1450 web-based training course
- Medicare EDI Helplines document

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