#### **CMS-1500 Billing Instructions**

Line-by-line paper billing instructions for Oregon Medicaid providers



#### **Overview**

- This presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the CMS-1500 billing form correctly the first time.
- If applicable, this presentation is to be used in conjunction with General Rules, provider guidelines and supplemental information.
- We hope you find this tutorial helpful.



#### **Claims processing**

- Paper claims are scanned into the claims processing system using Optical Character Recognition (OCR).
  - For OCR, you must use commercial "red form" claim forms and make sure certain fields are left-aligned.
- Electronic claims (Web and electronic data interchange) do not require specific claim forms or field alignment. Make sure you bill electronically whenever possible.
- Claims process weekly. DMAP sends a Remittance Advice (RA) listing all claims adjudicated to the provider (with payment if appropriate).



#### Before you bill

- Verify client eligibility on the date of service.
  - AMH Licensed Residential Providers must verify Plan of Care to make sure to bill according to the plan.
- Make sure you bill all prior resources first. Medicaid (DMAP) is the payer of last resort.
- Bill electronically if possible. You only need to bill on paper if you need to submit attachments with your claim, the claim is over a year old, and other certain instances.
- If you must bill on paper, use commercially available "red form" versions of the current CMS-1500.



### Paper billing tips

- When submitting handwritten claim forms:
  - Use blue or black ink; never use red ink.
  - Make sure your handwriting is legible. Zeroes should look different from the letter "O," the number one ("1") different from the letter "I," etc.
  - Don't use liquid paper/whiteout to make corrections.
- If possible, submit no more than six lines of services per claim form.
  - If you need to bill more than six lines on a single claim, bill electronically. Then you don't need to complete multiple paper claim forms.
- Check your printer alignment.



#### **Form suppliers**

- DMAP does not supply the CMS-1500 form.
- You can purchase forms by contacting one of the following:
  - Local business forms suppliers
  - Oregon Medical Association (503-226-1555)
  - U.S. Government Printing Office (202-512-1800)
- If you don't want to purchase claim forms, you can use the Provider Web Portal for free!



PROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05		
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	Single Married Other	
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OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
EMPLOYER'S NAME OR SCHOOL NAME	C. OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME
	YES NO	
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
READ BACK OF FORM BEFORE COMPL	TING & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize
<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorito process this claim. I also request payment of government benefits below.</li> </ol>	e me release of any medical or other information necessary Ather to myself or to the party who accepts assignment	payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED	DATE	SIGNED
4. DATE OF CURRENT: ILLNESS (First symptom) OR MM   DD   YY INJURY (Accident) OR	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	
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7. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	
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		1
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#### 08-05 version

• Not sure if you are using the correct form?

The bottom right corner should say 08-05.

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)



#### **Top section**

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)       3. PATIENT'S BIRTH DATE       SEX       4. INSURED'S NAME (Last Name, First Name, Middle Initial)         5. PATIENT'S ADDRESS (No., Street)       6. PATIENT RELATIONSHIP TO INSURED       7. INSURED'S ADDRESS (No., Street)         CITY       STATE       8. PATIENT STATUS       CITY         ZIP CODE       TELEPHONE (Include Area Code)       Married       Other         Q. OTHEH INSURED'S NAME (Last Name, Hirst Name, Middle Initial)       0. IS PATIENT'S CONDITION HELATED TO:       11. INSURED'S POLICY GROUP OR FECA NUMBER         a. OTHER INSURED'S DATE OF BIRTH M       D       YES       NO       11. INSURED'S NAME OR SCHOOL NAME         b. OTHER INSURED'S NAME OR SCHOOL NAME       PYES       NO       . EMPLOYER'S NAME OR SCHOOL NAME       D. EMPLOYER'S NAME OR SCHOOL NAME         d. INSURANCE PLAN NAME OR PROGRAM NAME       100. RESERVED FOR LOCAL USE       0. IS THERE ANOTHER HEALTH BENEFIT PLAN?	(Medicare #) (Medicaid #) CHAMPUS (Sponsor's SSN) (Member II	A GROUP FECA OTHER HEALTH PLAN BLK LUNG ( <i>ID</i> ) (SSN or ID) (SSN) ( <i>ID</i> )	
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YES NO If yes, return to and complete item 9 a-d.			YES NO If yes, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.	<ol> <li>PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the to process this claim. I also request payment of government benefits either</li> </ol>	release of any medical or other information necessary	payment of medical benefits to the undersigned physician or supplier for
SIGNED DATE SIGNED	SIGNED	DATE	SIGNED

#### Red = Required

Division of Medical Assistance Programs

#### 

### **Box 1a - Required**

1a. INSURED'S I.D. NUMBER

(For Program in Item 1)

X X # # # X # X

- Client ID Number
  - Enter the client's eight-character Oregon Medicaid identification number.
  - Enter the number exactly as it appears on the Oregon Health ID (formerly Medical Care ID) or the client's Plan of Care.



### **Box 2 - Required**

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

#### **Patient, Your**

- Patient's Name
  - Enter the client's name exactly as it is printed on the Oregon Health ID (formerly Medical Care ID) or the client's Plan of Care.
  - Use the client's last name first.
  - Do not use nicknames.



### **Box 9 - Optional**

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

- Third Party Resource
  - If the client has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.
  - A code must be listed when the other insurance did not make a payment.
  - A code is always required when the client has more than one other insurance carrier.
  - AMH Adult Residential Providers Only enter "NC" in this field.
  - Other providers See next slide for TPR codes.



### Single carrier TPR codes

UD	Service under deductible
NC	Service not covered by insurance policy
PN	Patient not covered by insurance policy
IC	Insurance coverage canceled/terminated
IL	Insurance lapsed or not in effect on date of service
IP	Insurance payment went to policyholder
PP	Insurance payment went to patient
NA	Service not authorized or prior authorized by insurance
NE	Service not considered emergency by insurance
NP	Service not provided by primary care provider/facility
MB	Maximum benefits used for diagnosis/condition
RI	Requested information not received by insurance from patient
RP	Requested information not received by insurance from policyholder
MV	Motor Vehicle Accident Fund (MVAF) maximum benefits exhausted
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days
ОТ	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)



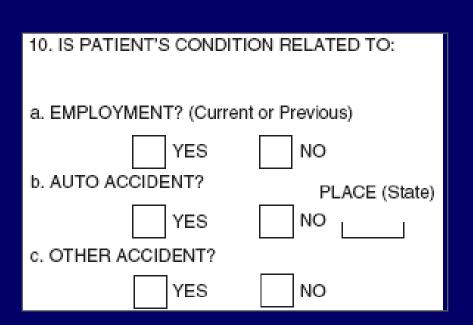
### **Multiple carrier TPR codes**

MP	Primary insurance paid – secondary paid
SU	Primary insurance paid – secondary under deductible
MU	Primary and secondary under deductible
PU	Primary insurance under deductible – secondary paid
SS	Primary insurance paid – secondary service not covered
SC	Primary insurance paid – secondary patient not covered
ST	Primary insurance paid – secondary canceled/terminated
SL	Primary insurance paid – secondary lapsed or not in effect
SP	Primary insurance paid – secondary payment went to patient
SH	Primary insurance paid – secondary payment went to policyholder
SA	Primary insurance paid – secondary denied – service not authorized
SE	Primary insurance paid – secondary denied – service not considered emergency
SF	Primary insurance paid – secondary denied – service not provided by primary care provider/facility
SM	Primary insurance paid – secondary denied – maximum benefits used for diagnosis/condition
SI	Primary insurance paid – secondary denied – requested information not received from policyholder
SR	Primary paid – Secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
МО	Other (If above codes do not apply, include detailed explanation of why no TPR payment was made)





### **Box 10 - Optional**



#### Patient's Condition

- Check the appropriate box only when an injury is involved.
- Do not check any boxes if there is no injury to report.



#### **Middle section**

14. DATE OF CURRENT: MM DD YY INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY MM DD YY FROM TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items	1, 2, 3 or 4 to Item 24E by Line)	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
2	4	3. PRIOR AUTHORIZATION NUMBER

#### **Red** = Required

#### Yellow = Optional



### **Box 17a - Optional**

17a. ######

- Referring Provider Number
  - Enter the six (6)-or nine (9)-digit DMAP provider number of the referring provider.
- This may be required if the client has a Primary Care Manager (PCM) or the service requires a referral (*e.g.*, Physical Therapy, Occupational Therapy or Speech Therapy).
- This field is required for AMH Adult Residential Providers.



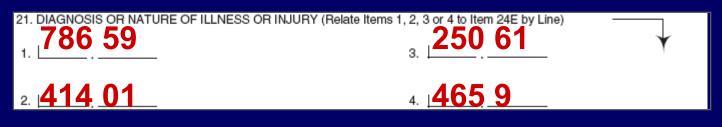
### **Box 17b - Optional**

#### 17b. NPI ##########

- National Provider Identifier (NPI) for referring provider
  - If you entered a DMAP provider in Box 17a (Primary Care Manager, or other referral), enter the 10-digit NPI registered under the DMAP provider ID used in Box 17a.
  - If you do not know what NPI to use, contact DMAP Provider Enrollment (800-422-5047).



### **Box 21 - Required**



- Diagnosis Code
  - Enter the ICD-9-CM code(s) for the client's diagnosis/condition.
  - The diagnosis code must be the reason chiefly responsible for the service being provided as shown in medical records.
  - You may enter up to four codes and they must be carried out to the highest degree of specificity.
  - Do not enter a decimal point.
  - Note: Diagnosis codes are not required for transportation providers or AMH Adult Residential Providers.



### **Box 23 - Optional**

23. PRIOR AUTHORIZATION NUMBER # # # # # # # # # #

- Prior Authorization Number
  - If the service you provided requires prior authorization (PA), enter the ten-digit prior authorization number that was issued for the service.
  - Only use one prior authorization number per claim form.
  - Do not bill prior authorized and non-authorized services on the same claim form.



#### **Bottom section**

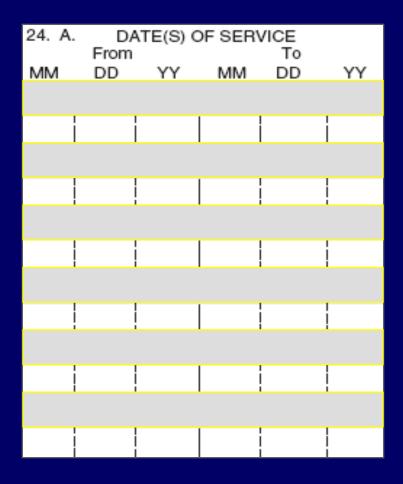
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**Red** = Required

#### Yellow = Optional



### **Supplemental information – Optional**



In the shaded area above each detail line, enter additional information about the line item (*e.g.*, NDC).

 If entering more than one item on a line, make sure each item begins with a qualifier and is separated by at least 1 blank space.



### **Supplemental qualifiers**

#### Use when reporting the following services:

Qualifier	Description
7	Anesthesia
ZZ	Narrative description of unspecified codes
VP	Vendor Product Number
OZ	Health Care Uniform Code
CTR	Contract rate
N4	<ul> <li>National Drug Code. Also use the following units of measure:</li> <li>F2 - International unit</li> <li>GR - Gram</li> <li>ML - Milliliter</li> <li>UN - Unit</li> </ul>



### **Supplemental information examples**

#### National Drug Code

24. A.	DA1 From	TE(S) O	F SERV	ICE To		B. PLACE OF	C.		S, SERVICES, OR SUPPLIES sual Circumstances)	E. DIAGNOSIS	F.	G. DAYS	H. EPSDT Family	I. ID.	J. RENDERING
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MM	DD	YY	MM	DD	ΥY	1		J####	UD [for 340B drugs]	1	### ##	20		NPI	1234567890

#### Anesthesia Services, in 15-minute units

24. A. MM	D/ From DD	ATE(S) C	DF SER	VICE To DD	vv	B. PLACE OF SERVICE	C. EMG		S. SERVICES, OR SUPPLIES isual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSOT Family Plan	I. ID.	J. RENDERING PROVIDER ID. #
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#### **Unspecified Code**

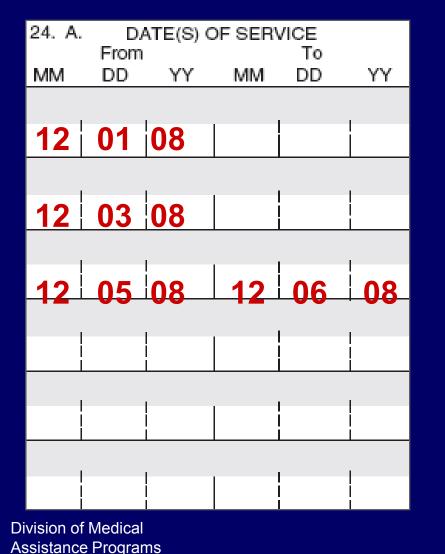
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ZZ	Kay	e Wa	lker												123456
06	01	07	06	01	07	4		E1399		1	### ##	1		NPI	1234567890

#### Vendor Product Number

24. A. MM	D From DD	Sec. 1.4	OF SEF	To To DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SE (Explain Unusual CPT/HCPCS	ERVICES, OR SUPPLIES Circumstances) MODIFIER	E. DIAGNOSIS POINTER	F. \$ CHARGES	G DAYS OR UNITS	H. EPSOT Family Plan	L ID. QUAL	J. RENDERING PROVIDER ID. #
VP	A12	22BIC	C5D6	E7G				-							123456
06	01	07	06	01	07	1		A6410		1	##	##		NPI	1234567890



### **Box 24A - Required**



• Date of Service

- This box must list numeric dates.
- If billing for one day, complete only the "from" column.
- Only use From and To dates for a service given on consecutive days and provided no more than once a day.

regor

### **Box 24B - Required**

•

**Place of Service** 

was provided.

database.pdf.

Adult foster homes use 12

Enter the two-digit CMS code for where the service

Residential treatment facilities must use 56

codebooks and on the CMS Web site at

CMS Place of Service codes are in CPT/HCPCS

www.cms.hhs.gov/placeofservicecodes/downloads/pos

SERVICE  $\bullet$ 11 11 **Division of Medical** 

Assistance Programs

B. PLACE OF



#### **Box 24C - Optional**

- Emergency Flag
  - If the service you provided was a result of an emergency, enter a "Y" for "yes" in this box for each line item.
  - If this was not an emergent service, leave blank or enter a "N" for "non-emergent".



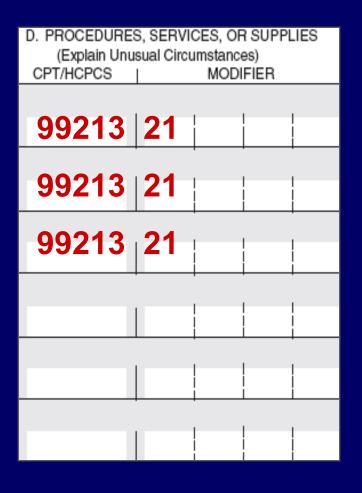
C.

EMG

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### **Box 24D - Required**



Division of Medical Assistance Programs Procedure Code

- Enter the five-digit/ character CPT or HCPCS code(s) for the specific service provided.
- Optional Enter up to four two-digit national modifiers that relate to this service.
- For procedure codes that indicate "unlisted," you must attach an operative/medical report.
- AMH Adult Residential Providers should only bill using the codes on the next slide.



# Procedure codes and modifiers for AMH adult residential providers

Adult Foster Home	Procedure S5141 Modifier HK
Residential Treatment Home	Procedure S5140 Modifier HK
<b>Residential Treatment Facility</b>	Procedure T2048 Modifier HK
Secure Residential Treatment Facility	Procedure T2048 Modifiers HK and TG



### **Box 24E - Required**

ightarrow

E. DIAGNOSIS POINTER 1 1 1

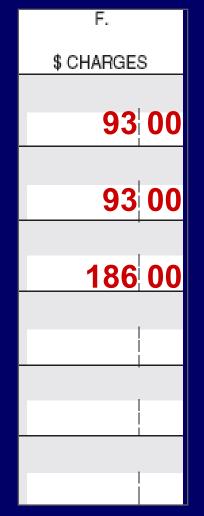
Division of Medical Assistance Programs

#### **Diagnosis** Pointer

- Enter the one-digit diagnosis code reference number (pointer) as shown in box 21 to relate the date of service and the procedure performed to the primary diagnosis.
- Do not enter the actual ICD-9-CM code here.



### **Box 24F - Required**



Division of Medical Assistance Programs

#### Total Charges

- Enter the total usual and customary charge for each line.
- Do not list credits.
- Do not use dashes.
- DMAP will not calculate your charge if billing for more than 1 item (unit).



#### **Box 24G - Required**

24A.

 $\bullet$ 

Service Days or Units

service provided.

Division of Medical Assistance Programs

G. DAYS OR UNITS

1

1

2

## For Residential Treatment, 1 unit = 1 day

Enter the number of days or units for each number of

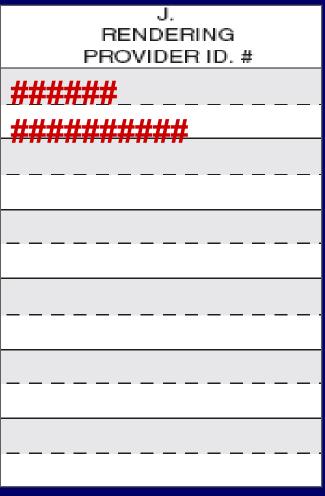
consecutive days or services as indicated in box

Some services are billed by units depending on the

– For Adult Foster Homes, 1 unit = 1 month



### **Box 24J - Optional**



Division of Medical Assistance Programs Rendering Provider ID

- Only required for AMH Adult Residential Providers, or when clinics or group practices use a specific billing provider number in Box 33.
- Shaded Enter the DMAP provider number of the rendering provider.
- Non-shaded Enter the NPI registered with the rendering DMAP provider ID.



### **Box 26 - Optional**

#### 26. PATIENT'S ACCOUNT NO.

#### X123400

- Patient Account Number
  - Enter your patient account number here.
  - This box allows up to twelve characters.
  - This number will appear on your Remittance Advice (RA).





- Total Charge
  - Enter the total charge amount for all services listed in column 24F.
  - Each claim form is a separate document, and is to be totaled as such.



### **Box 29 - Optional**

29. AMOUNT PAID

- Amount Paid
  - Enter the total amount paid by any prior resource(s).
  - For AMH Adult Residential Providers, this includes client responsibility.
  - Do not include write-offs.
  - Do not include how much DMAP previously paid.
  - Do not include copayments.





- Balance Due
  - Enter the balance due.
  - Box 28 minus Box 29 must equal Box 30.





#### **Box 33 - Required**

- Billing Provider Information Enter information for the provider number DMAP will direct payment to:
  - Box 33 Enter the name and address of the billing provider.
  - 33a Enter the NPI registered with the billing provider's DMAP ID number (listed in Box 33b).
  - 33b Enter the billing provider's DMAP ID.
- Note: Non-medical services (*e.g.*, taxis) do not require NPI.



#### Completed CMS-1500 claim form

### EXAMPLES



Medical
Clinic

1500														
HEALTH INSUR	ANCE CLAI	M FOR	М											
APPROVED BY NATIONAL UN	NIFORM CLAIM COMM	AITTEE 08/05	5											
PICA											PICA			
CHAMPUS HEALTH PLAN BLKLUNG								R 1a. INSURED'S I.D. NUMBER (For Program in Item 1)						
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					pouse Child	Other								
CITY			STATE 8.	8. PATIENT STATUS			CITY				STATE			
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SIGNED				DATE	E		SIGNED							
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#### AMH Adult Residential

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			Single	Married	Other						
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#### Resources

Where to mail your claim	DMAP PO Box 14955 Salem, OR 97309-4955
Help with paper billing	DMAP Provider Services 1-800-336-6016 E-mail: <u>dmap.providerservices@state.or.us</u>
Provider Web Portal – Free paperless Web billing (for individual claims)	https://www.or-medicaid.gov
Electronic business practices (billing, payment and more)	www.oregon.gov/DHS/healthplan/ebp.shtml
Provider training	www.oregon.gov/DHS/healthplan/tools_pro v/training.shtml



## **THANK YOU!**

