MassHealth

Billing Guide for the CMS-1500

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Introduction

This guide provides detailed instructions for completing the CMS-1500 claim form for MassHealth billing. Additional instructions on other billing matters, including member eligibility, prior authorization, claim status and payment, claim correction, and billing for members with other health insurance, are located in Subchapter 5 of your MassHealth provider manual, or refer to Appendix A of your MassHealth provider manual. Appendix A is available on the MassHealth Web site at www.mass.gov/masshealthpubs. Click on Provider Library, then on MassHealth Provider Manual Appendices.

For information about the resulting remittance advice, see the MassHealth Guide to the Remittance Advice for Paper Claims and Electronic Equivalents.

Please Note: Effective January 1, 2012, MassHealth adopted an all-electronic claims submission policy to achieve greater efficiency. All claims must be submitted electronically, unless the provider has received an approved electronic claim submission waiver. Ninety-day waiver requests and final deadline appeals may be submitted either electronically via the Provider Online Service Center (POSC) or on paper.

Please see All Provider Bulletin 217, dated September 2011, and All Provider Bulletin 223, dated February 2012, for more information about MassHealth's paper claims waiver policy. For information on how to submit 90-day waiver requests and final deadline appeals electronically, please also see All Provider Bulletin 220 and All Provider Bulletin 221, both dated December 2011, and All Provider Bulletin 226, dated June 2012.

General Instructions for Submitting Paper Claims

CMS-1500 Claim Form

The following providers must use the CMS-1500 when submitting paper claims to MassHealth.

- abortion clinics
- acute inpatient hospitals (for professional services provided by hospital-based physicians only)
- acute, chronic, and psychiatric outpatient hospitals (for professional services provided by hospital-based physicians only)
- adult day health providers
- adult foster care providers
- audiologists
- chiropractors
- community health centers (professional services only)
- day habilitation providers
- durable medical equipment providers
- early intervention providers
- family planning agencies
- freestanding ambulatory surgery centers
- group adult foster care providers
- hearing instrument specialists
- home-care corporations (elderly waiver)
- hospital-licensed health centers (for professional services provided by hospital-based physicians only)
- independent clinical laboratories
- independent diagnostic testing facilities
- independent living centers
- independent nurses
- independent nurse midwives
- independent nurse practitioners
- Indian health centers
- mental health centers
- municipally based health service providers
- ocularists
- opticians
- optometrists
- optometry schools
- orthotics providers
- oxygen and respiratory therapy equipment providers
- personal care agencies
- personal care attendant (PCA) fiscal intermediaries
- physicians

- podiatrists
- prosthetics providers
- psychiatric day treatment providers
- psychologists
- qualified-Medicare-beneficiaries-only providers (QMB-only) submitting crossover claims
- rehabilitation centers
- renal dialysis centers
- speech and hearing centers
- sterilization clinics
- substance use disorder treatment programs
- targeted case management programs
- therapists
- transportation providers

Entering Information on the CMS-1500 Claim Form

- Complete a separate claim form for each member to whom services were provided.
- Type or print all applicable information (as stated in the instructions) on the claim form, using black ink only. Be sure all entries are complete, accurate, and legible.
- For each claim line, enter all required information as applicable, repeating if necessary. Do not use ditto marks or words such as "same as above."
- Attach any necessary reports or required forms to the claim form.
- When a required entry is a date, enter the date in MMDDYY or MMDDYYYY format.

  Example: For a member born on February 28, 1960, the entry would be as follows: 02281960.

Time Limitations on the Submission of Claims

Claims must be received by MassHealth within 90 days from the date of service or the date of the explanation of benefits from another insurer. For additional information about the deadlines for submitting claims, please see MassHealth billing regulations (beginning at 130 CMR 450.309).

Claims for Members with Medicare or Other Health-Insurance Coverage

Special instructions for submitting claims for services furnished to members with Medicare or health-insurance coverage are contained in Subchapter 5 of your MassHealth provider manual.

Provider Preventable Conditions

See Appendix V of your provider manual for more information on how to bill for Provider Preventable Conditions (PPCs).

340B Drugs

The enactment of the Veterans Health Care Act of 1992 resulted in the 340B Drug Pricing Program, which is Section 340B of the Public Health Service Act. Through this program, providers who qualify as 340B-covered entities are able to acquire drugs at significantly discounted rates. Because of the discounted acquisition cost, these drugs are not eligible for the Medicaid Drug Rebate Program. Accordingly, state Medicaid programs must be able to distinguish between claims for 340B drugs and claims that are not for 340B drugs.

In order for providers to identify when they are submitting claims for physician-administered 340B drugs in an office or clinic setting, the National Medicaid Electronic Data Interchange HIPAA workgroup has recommended the use of the UD modifier. This will allow Medicaid programs to identify claims for 340B drugs and exclude them from the Medicaid drug rebate collection process.

MassHealth is implementing the recommended approach. Providers subject to this billing guide who participate in the 340B program must bill using the UD modifier on the CMS-1500, along with the applicable HCPCS code, when submitting claims for physician administered 340B drugs in an office or clinic setting. Please note that NDC codes are also required on these claims. See Field 24 for instructions.

Electronic Claims

To submit electronic claims, refer to Subchapter 5, Part 3, of your MassHealth provider manual or contact MassHealth Customer Service. Refer to Appendix A of your MassHealth provider manual for contact information.

Please Note: When submitting electronic files to MassHealth, be sure to review this CMS-1500 billing guide, the appropriate companion guides, and our billing tips flyers to determine the appropriate requirements for submitting electronic files to MassHealth. These documents can be found on the MassHealth website at mass.gov/masshealth.

Where to Send Paper Claim Forms

Appendix A of your MassHealth provider manual describes where to submit paper claims. Keep a copy of the submitted claim for your records. Please note that MassHealth does not accept mail with postage due.

Further Assistance

If, after reviewing the following instructions for completing the CMS-1500 claim form, you need additional assistance, you can contact MassHealth Customer Service. Please refer to Appendix A of your MassHealth provider manual for all MassHealth Customer Service contact information.

How to Complete the CMS-1500 Claim Form

A sample CMS-1500 claim form is shown below. Following this sample are instructions for completing each field on the CMS-1500 claim form. Refer to the National Uniform Claim Committee (NUCC) instruction manual available at www.nucc.org. Many types of providers use the CMS-1500 claim form to bill MassHealth for services. In some cases, special instructions have been provided for specific services or situations. Complete each field as instructed generally and follow specific instructions for your provider type or situation, as applicable.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

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CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)
1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
CITY STATE
8. RESERVED FOR NUCC USE
CITY STATE
ZIP CODE TELEPHONE (Include Area Code) ( )
ZIP CODE TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (Current or Previous) YES NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE
b. AUTO ACCIDENT? YES NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE
c. OTHER ACCIDENT? YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

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.
SIGNED DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. 17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D. E. F. G. H. I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED DATE
32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.
33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

How to Complete the CMS-1500 Claim Form (cont.)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

SAMPLE

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
1	(Unnamed)	Indicate the type of health-insurance coverage applicable to this claim by placing an X in the appropriate box. Only one box can be marked.
1a	Insured's I.D. Number	Enter the complete 12-character member identification (ID) number that is printed on the MassHealth card.
2	Patient's name	Enter the name of the MassHealth member receiving services in the following order: last name, first name, middle initial.
3	Patient's Birth Date	Enter the patient's eight-digit birth date in MMDDYYYY format.
	Sex	Enter an X in the correct box to indicate the gender of the patient. Only one box can be marked. If the gender is unknown, leave this field blank.
4	Insured's Name	If the member has other insurance, enter the insured's name in the following order: last name, first name, middle initial.
5	Patient's Address	Required
6	Patient Relationship to Insured	Enter an X in the correct box to indicate the patient's relationship to the insured. Only one box can be marked.
7	Insured's Address	Not required
8	Reserved for NUCC Use	Not required
9	Other Insured's Name	If Field 11d has an entry, complete Fields 9, 9a, and 9d, as applicable. When additional group health coverage exists, enter the name of the other insured in the following order: last name, first name, middle initial.
9a	Other Insured's Policy or Group Number	Enter the policy or group number of the other insured, if applicable.
9b	Reserved for NUCC Use	Not required
9c	Reserved for NUCC Use	Not required
9d	Insurance Plan Name or Program Name	Enter the seven-digit MassHealth third-party-liability carrier code. Refer to Appendix C of your MassHealth provider manual for carrier code values.
10a	Is Patient's Condition Related to Employment?	Enter an X in the appropriate box to indicate whether the condition is employment-related.
10b	Auto Accident? Place (State)	Enter an X in the appropriate box to indicate the type of accident. If Yes is marked, also enter the state postal code where the accident occurred.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
10c	Other Accident?	Enter an X in the appropriate box to indicate if the condition is the result of any other type of accident.
10d	Claim Codes (Designated by NUCC)	Not required
11	Insured's Policy Group or FECA Number	If applicable, enter the insured's policy or group number as it appears on the insured's health-care identification card. If Field 4 is completed, this field must also be completed.
11a	Insured's Date of Birth	Enter the insured's eight-digit birth date in MMDDYYYY format.
	Sex	Enter an X in the correct box to indicate the gender of the patient. Only one box can be marked. If the gender is unknown, leave this field blank.
11b	Other Claim ID (Designated by NUCC)	Not required
11c	Insurance Plan Name or Program Name	Enter the seven-digit MassHealth third-party-liability carrier code. Refer to Appendix C of your MassHealth provider manual for carrier code values.
11d	Is There Another Health Benefit Plan?	Enter an X in the appropriate box to indicate whether or not there is another health benefit plan. If Yes, complete Fields 9, 9a, and 9d. Make an entry in only one box.
12	Patient's or Authorized Person's Signature	Not required
13	Insured's or Authorized Person's Signature	Not required
14	Date of Current Illness, Injury, or Pregnancy (LMP)	Enter the start date of the present illness, injury, or condition in MMDDYYYY or MMDDYY format. For pregnancy, use the date of the last menstrual period (LMP). Enter one of the following qualifiers to indicate which date is being reported: • 431: Onset of Current Symptoms of Illness • 484: Last Menstrual Period

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
15	Other Date	Enter another date related to the patient's condition or treatment in MMDDYYYY or MMDDYY format. Enter one of the following qualifiers to identify which date is being reported: • 454: Initial Treatment • 304: Latest visit or Consultation • 453: Acute Manifestation of a Chronic Condition • 439: Accident • 455: Last X ray • 471: Prescription • 090: Report Start (Assumed Care Date) • 091: Report End (Relinquished Care Date) • 444: First Visit or Consultation
	Qual	Enter the qualifier between the left-hand set of vertical, dotted lines.
16	Dates Patient Unable to Work in Current Occupation	Not required
17	Name of Referring Provider or Other Source	Enter the name and credentials of the professional who referred, ordered, or supervised the service(s) or supply(ies) on the claim in the following order: first name, middle initial, last name. If multiple providers are involved, enter one provider using the following priority order: 1. Referring Provider 2. Ordering Provider 3. Supervising Provider Do not use periods or commas. A hyphen can be used for hyphenated names. Enter one of the following qualifiers to identify which provider is being reported: • DN: Referring Provider • DK: Ordering Provider • DQ: Supervising Provider Enter the qualifier to the left of the vertical, dotted line.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
17a	(Unnamed)	Enter the other ID number of the referring, ordering, or supervising provider in the shaded area of this field. In the box to the immediate right of "17a." enter one of the following qualifiers to identify what other ID number is being reported: • 0B: State License Number • 1G: Provider UPIN Number • G2: Provider Commercial Number (MassHealth Provider ID) • LU: Location Number (for supervising provider only)
17b	NPI	Enter the NPI number of the referring provider. If the referring provider does not have an NPI, this field is not required.
18	Hospitalization Dates Related to Current Services	If the member has been hospitalized, enter the inpatient hospital admission start date and discharge date (if the patient has been discharged) in MM/DD/YYYY format. If the patient has not been discharged, leave the discharge date blank. *Psychiatric Day Treatment Providers:* Enter the date of the member's discharge from the program.
19	Additional Claim Information (Designated by NUCC)	Not required. Previously, this field was used to report information about Durable Medical Equipment repairs. When submitting a claim for a repair that does not require prior authorization, provide the following information in an attachment: • the name of the person who requested the repair; • the date of the request and a specific description of the equipment malfunction; • a list of procedures and parts used to complete the repair; • the cost of each procedure and part; and • the time required to complete the repair.
20	Outside Lab? $ Charges	Not required

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
21	Diagnosis or Nature of Illness or Injury Relate A–L to service line below (24E)	Between the vertical, dotted lines labeled "ICD Ind." in the upper right-hand portion of the field, enter one of the following indicators to identify which version of ICD codes are being reported: • 9: ICD-9-CM • 0: ICD-10-CM Relate lines A through L to the lines of service in Field 24E by line letter. Use the highest level of specificity. Do not provide a narrative description in this field.
22	Resubmission Code	When resubmitting a claim, enter one of the following bill frequency codes left-justified in the left-hand portion of this field: • 7: Replacement of prior claim • 8: Void/cancel of prior claim
	Original Ref. No.	In the right-hand portion of the field, enter the 13-character internal control number (ICN) assigned to the paid claim. This ICN appears on the remittance advice on which the original claim was paid. Please refer to Subchapter 5, Part 6, of your MassHealth provider manual for detailed billing instructions on claim status and correction.
23	Prior Authorization Number	Enter the prior-authorization number or referral number assigned by MassHealth, if applicable.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24	(Unnamed Shaded Area)	Note: Each of the six rows designated for field 24 contains an upper, shaded area and a lower, unshaded area. Enter information in the shaded and unshaded areas as follows: • Shaded/upper area: drugs; injectable devices; durable medical equipment; oxygen and respiratory therapy equipment; prosthetics and orthotics. • Unshaded/lower area: date of current illness, injury, or pregnancy; place of service; emergency status; procedures, services, or supplies; diagnosis pointer; charges; days/units; etc. Enter the following information in the **shaded area** of Lines 1-6 from the beginning of 24A to the end of 24G for up to 61 characters. *For Drugs or Injectable Devices Administered in the Office or in a Clinic setting*: If billing for physician-administered drugs (including 340B drugs) or injectable devices administered in an office or clinic setting, except vaccines, enter the following information. • Qualifier N4; • the 11-digit national drug code (NDC); • the NDC unit of measure; and • the quantity of the drug administered. This information is in addition to the Healthcare Common Procedure Coding System (HCPCS) code entered in the unshaded section on the same line. Use the following qualifiers when reporting NDC unit descriptors. • F2: international unit (for example, anti-hemophilia factor); • GR: gram (for creams, ointments, and bulk powders); • ME: milligram (for creams, ointments, and bulk powders); • ML: milliliter (for liquids, suspensions, solutions, and lotions); and • UN: unit (for tablets, capsules, suppositories, and powder-filled vials). *For Compound Drugs* When billing for compound drugs, use the following qualifiers. • VY: used to identify that a compound drug is being dispensed; and • the compound drug association number (a three-digit compound drug association number indicates that the ingredients are part of the same compound drug). This number can only be three digits in length, and the submitter must make sure that all ingredients of the compound prescription have the same compound drug association number. List each drug ingredient that is part of the compound on a separate line with the VY qualifier and a compound drug association number segment. Make sure that all the individual ingredients that make up the compound have the same compound drug association number.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24	(Unnamed Shaded Area) cont.	

Examples

If billing for a drug administered in a doctor's office other than a compound drug, enter the following in the shaded area.

- Qualifier N4;
- the 11-digit national drug code (NDC);
- the NDC unit of measure (use one of the following qualifiers when reporting NDC units (F2, GR, ME, ML or UN)); and
- the quantity of the drug administered, which includes fractions.

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES

1 N4XXXXXXXXXXXUN00000001.500

If billing for a compound drug administered in a doctor's office, enter the following in the shaded area.

- Qualifier N4;
- the 11-digit national drug code (NDC);
- the NDC unit of measure (use one of the following unit descriptors when reporting NDC units (F2, GR, ME, ML or UN));
- the quantity of the drug administered, which includes fractions;
- reference identification qualifier – Value is VY; and
- compound drug association number (a three-digit compound drug association number indicating that the ingredients are part of the same compound drug). This number can only be three digits in length, and the submitter must make sure that all ingredients of the compound prescription have the same compound drug association number.

Please Note: The shaded area should be completed for each ingredient that makes up the compound prescription. Please use a separate line for each ingredient.

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS

1 N4XXXXXXXXXXXUN00000001.500VY000

2 N4XXXXXXXXXXXUN00000001.500VY000

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24.	(Unnamed Shaded Area) cont.	*For Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment, Prosthetics and Orthotics:* When billing HCPCS service codes that **do not** require prior authorization, and are payable on an individual consideration (I.C.) basis, enter the acquisition cost in addition to the quantity dispensed **in the shaded area**. Also attach a copy of the supplier's current invoice. Invoices submitted with a claim must be dated no more than 12 months before the date of service. Providers must submit the current invoice, and identify on the invoice the item(s) being billed on the claim by circling the item on the invoice, and the associated HCPCS service code being billed. Providers should refer to the MassHealth regulations, Subchapter 6 (Service Codes and Descriptions) of their MassHealth provider manual, and the MassHealth Payment and Coverage Guidelines Tool(s) for more information on payment and coverage criteria for service codes that are payable on an individual consideration (I.C.) basis.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24A	Date(s) of Service (for lower, unshaded area)	Enter the date the service was provided in MMDDYYYY format in the **unshaded area**. *For a Single Date of Service:* In the “From” column, enter the date the service was provided in MMDDYYYY format. Leave the “To” column blank. *For Consecutive Dates of Service:* In the “From” column, enter the first date of service. In the “To” column, enter the last date of service. Billing for consecutive dates of service on a single claim line is allowed for only certain services. For example, a physician may bill for hospital visits on successive days by entering the dates of service in the “From” and “To” boxes, but a physician may not bill for office visits on successive days on a single claim line. *Early Intervention Providers:* *For Assessments:* Enter the date the assessment was completed in the "From” column. In Field 24G, enter the total number of units spent on the assessment, regardless of the date. *For All Other Early Intervention Services:* Follow the instructions given in the general description. *Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment, and Pharmacy providers that have a DME and/or Oxygen specialty:* *For Monthly Rentals:* Enter the last date of the monthly rental period in “From.” Leave “To” blank. Use a separate claim line for each monthly rental period. *For Substitute Rentals:* Enter the date of service in “From.” Leave “To” blank. Use a separate claim line for each rental day. *For Purchases and Repairs:* Enter the date when the service was furnished in “From.” Leave “To” blank.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24B	Place of Service	Enter the appropriate two-digit code from the place-of-service code list for each item used or service performed. The place-of-service codes are available at: http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html. *Acute Hospitals billing for Professional Services where the service is provided by hospital-based physicians only:* To help define the type of facility billing for medical services on a professional claim please use the following place-of-service codes. 21 – Inpatient hospital 22 – Outpatient hospital 23 – Emergency room 99 – Hospital-licensed health center *Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment, Orthotics and Prosthetic Providers:* Providers should refer to the MassHealth Payment and Coverage Guideline Tool(s) for the place-of-service codes attached to the HCPCS. 12 – Home 31 – Skilled nursing facility 32 – Nursing facility 33 – Custodial care
24C	EMG	Indicate if the service is the result of an emergency. Enter Y or leave it blank.
24D	Procedures, Services, or Supplies CPT/HCPCS Modifier	Enter the CPT or HCPCS code(s) and modifier(s). This field accommodates up to four two-digit modifiers. See Subchapter 6 of the applicable MassHealth provider manual for lists of payable or nonpayable service codes and modifiers and their descriptions. *Municipally Based Health Service Providers:* Municipally based health service providers should refer to relevant municipally based health service provider bulletins to determine the correct service code. *Transportation Providers:* Use modifier “TS” when billing for more than two one-way trips for the same member on the same date of service. *340B-Covered Entities:* 340B-Covered Entities (e.g., Community Health Centers, Family Planning Clinics, Group Practices, and other providers participating in the 340B program). Use modifier “UD” next to appropriate HCPCS code when billing for a 340B drug.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24E	Diagnosis Pointer	If applicable, enter the diagnosis code reference letter (pointer) as shown in Field 21 to relate the date of service and the procedures performed to the primary diagnosis. (ICD-CM diagnosis codes must be entered in Field 21 only. Do not enter them in Field 24E.) When multiple services are performed, enter the primary reference for each service first, followed by other applicable services. The reference number should be a letter A through L, or multiple letters as explained in the previous sentence. Enter letters left-justified in the field. Do not use commas between the letters.
24F	$ Charges	Enter the provider's usual and customary fee (amount charged to a person who is not a MassHealth member). Enter the amount right-justified in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not enter negative dollar amounts. Enter "00" in the cents area if the amount is a whole number. *For Durable Medical Equipment, Oxygen and Respiratory Therapy Equipment, Prosthetics, and Orthotics:* When billing for these DME, oxygen/respiratory therapy equipment, orthotics, or prosthetics products that **do not** require prior authorization, and are listed in Subchapter 6 (Service Codes and Descriptions) of your MassHealth provider manual, and the MassHealth Payment and Coverage Guideline Tool(s) as not requiring individual consideration (IC), enter the provider's usual and customary charge on the claim. *For Medications and Injectables:* Enter the actual acquisition cost and attach a copy of the supplier's invoice to the claim. Invoices submitted with a claim must be dated no more than 12 months before the date of service. *Personal Care Agencies:* *For Functional Skills Training:* Enter the standard charge per member per month, regardless of the number of skills training sessions provided to the member in the month. *For Initial Evaluations and Reevaluations:* Enter the provider's usual and customary fee.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24G	Days or Units	Enter the appropriate number of units billed on the claim line for the service date. *For Consecutive Days of Service*: Enter the total number of days or units within the billing period. *For Nonconsecutive Dates of Service:* Enter "1" for each date of service or unit entered on the claim form. *For Anesthesia:* Enter the total number of minutes that make up the beginning and ending clock time for the anesthesia service. One minute equals one unit. See 130 CMR 433.000 for regulations about reporting anesthesia time. If no units are entered, the service is paid at the base rate.
24H	EPSDT Family Plan	*Early and Periodic Screening, Diagnosis, and Treatment:* Enter the response in the shaded portion of the field as follows. If there is no requirement (for example, state requirement) to report a reason code for EPSDT, enter "Y" for yes, or "N" for no. If there is a requirement to report a reason code for EPDST, enter the appropriate reason code as noted below. • AV: Available–Not Used (Patient refused referral.) • S2: Under Treatment (Patient is currently under treatment for referred diagnostic or corrective health problem.) • ST: New Service Requested (referral to another provider for diagnostic or corrective treatment/scheduled for another appointment with screening provider for diagnostic or corrective treatment for at least one health problem identified during an initial or periodic screening service, not including dental referrals) • NU: Not Used (when no EPSDT patient referral was given) *Family Planning:* If the service is for family planning, enter "Y" for yes, or "N" for no in the bottom unshaded area of the field.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
24I	ID Qual.	In the shaded area of Field 24I, enter the appropriate qualifier if the number is a non-national provider identifier (NPI). If the provider is an atypical provider and does not have an NPI, enter "G2." If the provider has an NPI and is providing taxonomy information, enter "PXC."
24J	Rendering Provider ID #	**Please Note:** This field is required for group practices only. All other providers must leave this field blank. If the shaded area of Field 24I is "G2," enter your MassHealth provider ID in the shaded area of Field 24J. If the shaded area of Field 24I is "PXC," enter the provider taxonomy code if applicable in the shaded area of Field 24J. Enter the provider's NPI in the unshaded area of Field 24J.
25	Federal Tax I.D. Number	Enter the service or supplier federal tax ID (employer identification number) or social security number for the provider. Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.
26	Patient's Account No.	Required. Enter the patient's account number, if one is assigned. Enter the member's last name if a patient account number is not assigned.
27	Accept Assignment? Yes or No	*For Non-Crossover Claims:* Leave this field blank. *For Medicare Crossover Claims:* Enter an X in the appropriate box to indicate whether the provider accepts assignment.
28	Total Charge	Enter the total charges for the services (that is, the total of all charges in Field 24F). Enter the amount in the dollar area of the field. Do not use commas or dollar signs when reporting dollar amounts. Do not enter negative dollar amounts. Enter "00" in the cents area if the amount is a whole number. This is a required field.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
29	Amount Paid $	Enter the total amount the patient or other payers paid on the covered services only. Do not use commas or dollar signs when reporting dollar amounts. Do not enter negative dollar amounts. Enter “00” in the cents area if the amount is a whole number.
30	Rsvd for NUCC Use	Not required
31	Signature of Physician or Supplier Including Degrees or Credentials, Date	Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, “Signature on File,” or “SOF.” Enter either a six-digit date (MM/DD/YY), eight-digit date (MM/DD/YYYY), or alphanumeric date (for example, January 10, 2008) on which the form was signed.
32	Service Facility Location Information	Enter the name, address, city, state, and zip code of the location where the services were provided. Providers of the service (physicians) must identify the supplier’s name, address, zip code, and NPI when billing for purchased diagnostic tests. When more than one supplier is used, use a separate CMS-1500 claim form for each supplier. Enter the name and address information in the following format: • 1st line: name • 2nd line: address (The billing provider address must be a street address. Do not use P.O. or lock boxes.) • 3rd line: city, state, and zip code Do not use commas, periods, or other punctuation in the address (for example, enter 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. When entering a nine-digit zip code, include a hyphen. Do not use P.O. or lock boxes.
32a	NPI	Enter the NPI of the service facility location in Field 32a.
32b	Other ID No.	Enter the appropriate two or three-character qualifier. If the provider is an atypical provider and does not have an NPI, enter “G2” followed by the provider’s 10-character MassHealth provider ID. If the provider has an NPI and is providing taxonomy information, enter “PXC” followed by the taxonomy code.

How to Complete the CMS-1500 Claim Form (cont.)

Field No.	Field Name	Description
33	Billing Provider Info & Phone #	Enter the provider's or supplier's billing name, doing business as (DBA) address, zip code, and phone number. Enter the phone number in the area to the right of the field title. Enter the name and address information in the following format: • 1st line – name • 2nd line – address (The billing provider address must be a street address. Do not use P.O. or lock boxes.) • 3rd line – city, state, and zip code Field 33 identifies the provider that is requesting to be paid for the services rendered and should always be completed. Do not use commas, periods, or other punctuation in the address (for example, enter 123 N Main Street 101 instead of 123 N. Main Street, #101). Enter a space between town name and state code; do not include a comma. Do not use P.O. or lock boxes. When entering a nine-digit zip code, include a hyphen. Do not use a hyphen or space as a separator within the telephone number.
33a	NPI	Enter the NPI of the billing provider.
33b	Other ID No.	Enter the appropriate two or three-character qualifier. If the provider is an atypical provider and does not have an NPI, enter "G2" followed by the provider's 10-character MassHealth provider ID. If the provider has an NPI and is providing taxonomy information, enter "PXC" followed by the taxonomy code.

Appendix A: TPL Supplemental Instructions for Submitting Claims on the CMS-1500 for Members with Medicare Coverage

Please Note: Effective January 1, 2012, MassHealth adopted an all-electronic claims submission policy to achieve greater efficiency. All claims must be submitted electronically, unless the provider has received an approved electronic claim submission waiver. Ninety-day waiver requests and final deadline appeals may be submitted either electronically via the POSC or on paper.

Please see All Provider Bulletin 217, dated September 2011, and All Provider Bulletin 223, dated February 2012, for more information about MassHealth's paper claims waiver policy. For information on how to submit 90-day waiver requests and final deadline appeals electronically, please also see All Provider Bulletin 220 and All Provider Bulletin 221, both dated December 2011, and All Provider Bulletin 226, dated June 2012.

Important: The table below lists specific fields on the CMS-1500 that must be completed for claims when the member has Medicare in addition to MassHealth.

Field #	Field Name	TPL Required Information
1	Unnamed	Check box marked "Medicare."
4	Insured's Name	Enter insured's name (subscriber and insured's name may be different from the MassHealth member's name)
6	Patient Relationship to Insured	Check the correct box to indicate the patient's relationship to the insured. Only one box can be marked.
9	Other Insured's Name	If 11d is checked "yes," enter the name of the insured if different from patient name.
9a	Other Insured's Policy or Group Number	If 11d is checked "yes," enter the group or policy number for the commercial insurance plan.
9d	Insurance Plan Name or Program Name	When 11d is checked "yes," enter the appropriate MassHealth carrier code. The Third-Party Liability MassHealth Carrier Code list can be found in Appendix C of your MassHealth provider manual.
11	Insured's Policy Group or FECA Number	Enter the policy or group number of the primary commercial insurance resource as it appears on the member's insurance card.
11a	Insured's Date of Birth, Sex	Enter insured's date of birth.

Appendix A: TPL Supplemental Instructions for Submitting Claims on the CMS-1500 for Members with Medicare Coverage (cont.)

Field #	Field Name	TPL Required Information
11c	Insurance Plan or Program Name	Enter the appropriate MassHealth carrier code. The Third-Party Liability MassHealth Carrier Code list can be found in Appendix C of your MassHealth provider manual.
11d	Is There Another Health Benefit Plan?	Check the box indicating whether the patient has insurance in **addition to MassHealth and Medicare.** If this box is checked "yes," complete Fields 9, 9a, and 9d with information applicable to the other commercial health plan.
27	Accept Assignment? Yes or No	Check the appropriate box to indicate whether the provider accepts assignment.
29	Amount Paid	Enter the total amount paid by all insurers **other than** MassHealth.

Instructions for submitting claims with Explanation of Medicare Benefits (EOMB)

1. Complete the CMS-1500 claim form according to this MassHealth Billing Guide for the CMS-1500.
2. Attach the original or a copy of the other insurance carrier's EOMB and completed TPL Claim Submission Form to the claim form.
   a. The dates of service, provider name, and patient's name on the EOMB must correspond to the information on the MassHealth claim.
   b. If more than one member is listed on the EOMB, circle the member information on the EOMB that corresponds to the member on the MassHealth claim.
   c. If you are submitting claims with one or more EOMB attachments, you must write the appropriate MassHealth assigned carrier code on each EOMB.

Please Note: MassHealth-assigned carrier codes may be found in Appendix C: Third-Party-Liability Codes of your MassHealth provider manual or at www.mass.gov/masshealth. Go to MassHealth Regulations and Other Publications, and then to the Provider Library.

Appendix B: TPL Supplemental Instructions for Submitting Claims on the CMS-1500 for Members with Commercial Insurance

Please Note: Effective January 1, 2012, MassHealth adopted an all-electronic claims submission policy to achieve greater efficiency. All claims must be submitted electronically, unless the provider has received an approved electronic claim submission waiver. Ninety-day waiver requests and final deadline appeals may be submitted either electronically via the POSC or on paper.

Please see All Provider Bulletin 217, dated September 2011, and All Provider Bulletin 223, dated February 2012, for more information about MassHealth's paper claims waiver policy. For information on how to submit 90-day waiver requests and final deadline appeals electronically, please also see All Provider Bulletin 220 and All Provider Bulletin 221, both dated December 2011, and All Provider Bulletin 226, dated June 2012.

Important: The table below lists specific fields on the CMS-1500 that must be completed for all MassHealth claims where the member has commercial insurance in addition to MassHealth. In addition to completing all applicable fields, all claims for members with commercial insurance must be submitted with the appropriate explanation of benefits (EOB) or other necessary TPL documentation. Providers must ensure that the appropriate carrier code is clearly written on the EOB.

Field #	Field Name	TPL Required Information
1	Unnamed	Check box marked "Medicaid."
1a	Insured's ID Number	Enter the 12-digit MassHealth member ID.
4	Insured's Name	Enter insured's name (subscriber and insured's name may be different from the MassHealth member's name)
6	Patient Relationship to Insured	Check the correct box to indicate the patient's relationship to the insured. Only one box can be marked.
9	Other Insured's Name	If 11d is checked "yes," enter the name of the insured if different from patient name.
9a	Other Insured's Policy or Group Number	If 11d is checked "yes," enter the group or policy number for the commercial insurance plan.
9d	Insurance Plan Name or Program Name	When 11d is checked "yes," enter the appropriate MassHealth carrier code. The Third-Party Liability MassHealth Carrier Code list can be found in Appendix C of your MassHealth provider manual.
11	Insured's Policy Group or FECA Number	Enter the policy or group number of the primary commercial insurance resource as it appears on the member's insurance card.
11a	Insured's Date of Birth, Sex	Enter insured's date of birth

Appendix B: TPL Supplemental Instructions for Submitting Claims on the CMS-1500 for Members with Commercial Insurance (cont.)

Field #	Field Name	TPL Required Information
11c	Insurance Plan or Program Name	Enter the appropriate MassHealth carrier code. The Third-Party Liability MassHealth Carrier Code list can be found in Appendix C of your MassHealth provider manual.
11d	Is There Another Health Benefit Plan?	Check the box indicating whether the patient has insurance in **addition to MassHealth and the commercial insurance identified in Fields 11-11c.** If this box is checked "yes," complete Fields 9, 9a, and 9d with information applicable to the other commercial health plan.
29	Amount Paid	Enter the total amount paid by all insurers **other than** MassHealth.

Instructions for submitting claims with Explanation of Benefits (EOB)

1. Complete the CMS-1500 claim form according to this MassHealth Billing Guide for the CMS-1500.
2. Attach the original or a copy of the other insurance carrier's EOB and completed TPL Claim Submission Form to the claim form.
   a. The dates of service, provider name, and patient's name on the EOB must correspond to the information on the MassHealth claim.
   b. If more than one member is listed on the EOB, circle the member information on the EOB that corresponds to the member on the MassHealth claim.
   c. If you are submitting claims with one or more EOB attachments, you must write the appropriate MassHealth assigned carrier code on each EOB.

Please Note: MassHealth-assigned carrier codes may be found in Appendix C: Third-Party-Liability Codes of your MassHealth provider manual or at www.mass.gov/masshealth. Go to MassHealth Regulations and Other Publications, and then to the Provider Library.