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Chapter 4. Billing Format

Some of the differences in reporting services for the physician and the facility are the result of the differences in the billing formats used. While the facility uses the UB-04 and 837i formats, the physician reports services using the CMS-1500 (08/05) and the 837p formats. The use of NPI numbers is mandatory as of May 23, 2008. The UB-04 billing form became effective in early 2007. The CMS-1500 (08/05) effective date was July 1, 2007.

In order to understand some of the differences, the CMS-1500 form will be explained in this chapter. The 837p also has the same data requirements with a few exceptions noted below. A comparison table of the CMS-1500 and the 837p will also be reviewed. Although you may never directly enter the information into the billing documents or system, an understanding of the required fields will help to provide all the correct information and reduce the likelihood of a denial or rejected claim.

Completing the CMS-1500

A picture is worth a thousand words, and the CMS-1500 health insurance claim form is the picture that tells payers what happened during a patient encounter. Basically, the CMS-1500 should tell all—the who, what, where, when, why, and how services were provided. It includes the necessary information that health insurers need to process payment and is the required form for the Medicare and Medicaid programs. It has also been adopted by the Tricare Support Office (TSO), successor of OCHAMPUS, and has received the approval of the American Medical Association Council on Medical Services.

Sometimes referred to as the AMA form, the CMS-1500 (08-05) is the standard form for claims prepared and submitted by physicians or suppliers (except for ambulance suppliers), whether or not the claims are assigned. It may be purchased in a variety of formats (e.g., single sheet, snap-out, continuous, etc.) and from any number of vendors.

Learning how to maneuver through this claim form is crucial. For instance, there are some Part B services that have special limitations on payments or that require special methods of benefit computation. Contractors monitor their processing systems to ensure that they recognize the procedure or diagnosis codes that involve services with special payment limitations or calculation requirements. Medicare contractors, using information extracted from the form, are able to identify services that are incidental to, or included in, a more extensive procedure or services that are part of a global procedure code (unbundling).

Quick Tips for Accurate Claim Completion

Following are some quick tips for completing a claim:

- CMS-1500 has space for physicians and suppliers to indicate that a patient has other health insurance. It is important that this information be provided since it is used by contractors to determine whether the Medicare patient has other coverage that must be billed prior to Medicare payment or whether there is a Medigap policy under which payments are made to a participating physician or supplier.
• Use the eight-digit dates in all date-of-birth items (items 3, 9b, and 11a) and either six-digit or eight-digit dates in all other date items (items 11b, 12, 14, 16, 18, 19, 24a, and 31).

• You have the option of entering six-digit or eight-digit dates in items 11b, 12, 14, 16, 18, 19, 24a, and 31. However, if you choose to enter eight-digit dates for items 11b, 14, 16, 18, 19, or 24a, the eight-digit dates must be indicated for all of these items. For instance, the provider may not enter eight-digit dates for items 11b, 14, 16, 18, and 19 and a six-digit date for item 24a. The same rule applies to providers who choose to submit six-digit dates. Items 12 and 31 are exempt from this requirement.

Claims that are Incomplete or Contain Invalid Information

If a claim is submitted with incomplete or invalid information, it will be returned to the provider as unprocessable. The term *returned as unprocessable* (RTP) is the payer's way of notifying a physician that his or her claim cannot be processed due to incomplete or incorrect information. Once the errors are corrected, the claim may be resubmitted and considered for payment.

A physician is required to submit a Medicare claim for beneficiaries who have received services whether or not the physician accepts assignment. Likewise, when you enter into a provider agreement with non-Medicare payers, you are more than likely responsible for submitting claims for services. Therefore, a physician who has not accepted assignment on a claim is required to correct claims returned as unprocessable so that a determination can be made on the claim. Unlike denied claims, claims returned as unprocessable do not have appeal rights.

The following is a sample of the CMS-1500 (08-05) form.
KNOWLEDGE ASSESSMENT QUESTIONS:

1. Which form is used primarily to report facility services and procedures?
   a. UB-04
   b. CMS 1500
   c. 837p
   d. 837i

2. When did the NPI become mandatory for all providers?
   a. January 1, 2009
   b. October 1, 2008
   c. January 1, 2010
   d. May 23, 2008

3. What is the electronic equivalent of the CMS-1500 form?
   a. 837i
   b. UB-04
   c. 837p
   d. PECOS

4. What does the acronym RTP stand for?
   a. Return to provider
   b. Refunded to provider
   c. Recycle to processing
   d. Return TIN of Provider

5. What organization provides the updates and oversight for the CMS-1500 form?
   a. Centers for Medicare and Medicaid Services
   b. National Uniform Claim Committee
   c. American Medical Association
   d. National Update Coordination Committee

6. What data element is required in Block 33a of the CMS-1500 form?
   a. Tax identification number
   b. Patient’s account number
   c. National provider identifier
   d. Insureds policy group number

7. What format is used to report physician and some outpatient services?
   a. UB-04 and 837p
   b. UB-04 and 837i
   c. CMS 1500 and 837p
   d. CMS 1500 and 837i
8. What information must be reported in block 17b when a service is ordered or a patient is referred to another physician?
   a. The NPI of the performing provider
   b. The federal tax id number of the performing provider
   c. The insured’s policy or group number
   d. The NPI of the referring provider

9. What block on the CMS-1500 contains the rendering provider’s NPI?
   a. 17b
   b. 24j
   c. 27
   d. 33b

10. What block on the CMS-1500 contains the performing provider’s information?
    a. 32, 32a, 32b
    b. 24j
    c. 17, 17a, 17b
    d. 33, 33a, 33b

11. What blocks are used to report authorization, referral, precertification, or CLIA numbers on the CMS-1500 form?
    a. 23
    b. 24j
    c. 20
    d. 15

12. A POS code must be included in what box of the CMS-1500 form in order for the claim to be processed?
    a. 24a
    b. 24b
    c. 24c
    d. 24d

13. Name the electronic equivalent for block 27 of the CMS-1500 form?
    a. Loop 2300 1 135 374 DTPO1
    b. Loop 2310A 2-271-REF02 (IG) OR
    c. Loop 2300 2-130-CLM07
    d. Loop 2010AA 2-015-NM103(85,1)