CMS-1500 Billing Guide for PROMISe™ Financial Management Services (FMS)

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 claim form:

- **Intermediate Service Organization – Provider Type 54, Specialties 540 and 541**

Document format

This document contains a table with four columns. Each column provides a specific piece of information as explained below:

- **Block Number** – Provides the block number as it appears on the claim.
- **Block Name** – Provides the block name as it appears on the claim.
- **Block Code** – Lists a code that denotes how the claim block should be treated. They are:

  M – Indicates that the claim block must be completed.

  A – Indicates that the claim block must be completed, if applicable.

  O – Indicates that the claim block is optional.

  LB – Indicates that the claim block should be left blank.

  *** –** Indicates special instruction for block completion.
- **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions or refer to the CMS-1500 Handbook for further clarification.

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IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1: If you are submitting handwritten claim forms you must use **blue** or **black** ink.

Note #2: **Font Sizes** — Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3: When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents**:

1. Block 24F ($Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your negotiated rate is sixty-five dollars and you enter 65, your negotiated rate may be read as .65 cents.

Note #4: **All claims submitted with an Administrative Fee and accompanying service <u>MUST BE BILLED IN A SPECIFIC ORDER:</u> The service should always be entered/listed on the claim detail line (service line) before the Administrative Fee.**

Example #1: When completing Block 24F, enter your negotiated rate, without a decimal point. You must include the dollars and cents. If your negotiated rate is fifteen dollars, enter:

24F	
$CHARGES	
15	00

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You must follow these instructions to complete the CMS-1500 claim when billing the Department of Human Services. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to Medical Assistance.

Block No.	Block Name	Block Code	Notes
1	Type of Claim	M	Place an **X** in the Medicaid box.
1a	Insured's ID Number	M	Enter the 10-digit beneficiary number found on the ACCESS card. If the beneficiary number is not available, access the Eligibility Verification System (EVS) by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit beneficiary number to use for this block.
2	Patient's Name	O	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim.
3	Patient's Birthdate and Sex	O	Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) and indicate the patient's gender by placing an **X** in the appropriate box.
4	Insured's Name	LB	Do not complete this block.
5	Patient's Address	O	Enter the patient's address.
6	Patient's Relationship to Insured	LB	Do not complete this block.
7	Insured's Address	LB	Do not complete this block.
8	Reserved for NUCC Use	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
9	Other Insured's Name	LB	Do not complete this block.
9a	Other Insured's Policy or Group Number	LB	Do not complete this block.
9b	Reserved for NUCC Use	LB	Do not complete this block.
9c	Reserved for NUCC Use	LB	Do not complete this block.
9d	Insurance Plan Name or Program Name	LB	Do not complete this block.
10a-10c	Is Patient's Condition Related To:	LB	Do not complete this block.
10d	Claim Codes (Designated by NUCC)	LB	Do not complete this block.
11	Insured's Policy Group or FECA Number	LB	Do not complete this block.
11a	Insured's Date of Birth and Sex	LB	Do not complete this block.
11b	Other Claim ID (Designated by NUCC)	LB	Do not complete this block.
11c	Insurance Plan Name or Program Name	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
11d	Is There Another Health Benefit Plan	LB	Do not complete this block.
12	Patient's or Authorized Person's Signature and Date	M/M	The beneficiary's signature or the words **Signature Exception** must appear in this field. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes. **Note:** Please refer to Section 6 of the PA PROMISe™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	O	If completed, this block should contain the signature of the insured, if the insured is not the patient.
14	Date of Current Illness, Injury or Pregnancy (LMP)	LB	Do not complete this block.
15	Other Date	LB	Do not complete this block.
16	Dates Patient Unable to Work in Current Occupation	LB	Do not complete this block.
17	Name of Referring Provider or Other Source	LB	Do not complete this block.
17a	I.D. Number of Referring	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
	Provider		
17b	NPI #	LB	Do not complete this block.
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.
19	Additional Claim Information (Designated by NUCC)	A/A	This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "**AT**", followed by a two-digit number (i.e., **AT99).** Attachment Type Code "**AT99"** indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the beneficiary's number on the top left-hand corner of the page. If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment. *For additional information on completing CMS-1500 claim form adjustments, please refer to Section 2.10 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.*
20	Outside Lab	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	The ICD indicator (ICD Ind) is required. If a valid "9" or "0" indicator is not entered into the ICD Ind. space, claims will be returned to the provider as incomplete. For dates of service **prior** to October 1, 2015, enter the most specific ICD-9-CM code (indicator "9"); **OR** for dates of service **on or after** October 1, 2015, enter the ICD-10-CM code (indicator "0") that describes the

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Block No.	Block Name	Block Code	Notes
			diagnosis. The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable.
22	Resubmission Code	A/A	This block has two uses: 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the **ORIGINAL** rejected claim in the right portion of this block (e.g., | 1103123523123). 2) When submitting a claim adjustment for a previously approved claim**.** If submitting a claim adjustment, enter ADJ in the left portion of the block and the **LAST APPROVED** 13-digit ICN, a space and the 2-digit line number from the RA Statement in the right portion of the block (e.g., ADJ | 1103123523123 01).
23	Prior Authorization Number	LB	Do not complete this block.
24a	Date(s) of Service	M/M	Enter the applicable date(s) of service. If billing for a service that was provided on one day only, complete either the **From** or the **To** column (but not both.). If the same service was provided on consecutive days, enter the first day of the service in the **From** column and the last day of service in the **To** column. Use an eight-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.
24b	Place of Service	M	Enter the two-digit place of service code that indicates where the service was performed.

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Block No.	Block Name	Block Code	Notes
24c	EMG	LB	Do not complete this block**.**
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/A/A	List the procedure code(s) for the service(s) being rendered and any applicable modifier(s). In the first section of the block, enter the procedure code that describes the service provided. In the second and subsequent portions of the modifier block(s), enter the modifier(s) (up to four) as they appear on your Service Authorization Notices (print or download view) which are found in Provider Access of the Home and Community Services Information System (HCSIS). . If modifiers are applicable to the services you are billing, please enter them in the exact order they appear on your Service Authorization Notices. **Failure to enter the modifier(s) in the appropriate order will result in denial.** **PLEASE NOTE:** All claims submitted with an Administrative Fee and accompanying service **MUST BE BILLED IN A SPECIFIC ORDER:** The service should always be entered/listed on the claim detail line (service line) first then the Administrative Fee should be billed second**.**
24e	Diagnosis Pointer	M/A	This block may contain up to four letters. Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21. If the service provided was for the primary diagnosis (in Block 21A), enter A. If provided for the secondary diagnosis, enter B. If provided for the third through twelfth diagnosis, enter the letter that corresponds to the applicable diagnosis. Note: The primary diagnosis pointer must be entered first.
24f	$Charges	M	For Base Services, enter your county negotiated rate for the service(s) provided. For example, if your usual charge is thirty-five dollars, enter **35 00 (The dollar and cents**

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Block No.	Block Name	Block Code	Notes
			amounts are two separate fields on the CMS1500 claim form) If billing for multiple units of service, multiply your county negotiated rate by the number of units billed and enter that amount. For Consolidated and P/FDS Waiver Services, please enter your charges for the service(s) rendered (calculated by taking the total number of units multiplied by the rate that is indicated on your Service Authorization Notice).
24g	Days or Units	M	Enter the number of units, services, or items provided.
24h	EPSDT/Family Planning	LB	Do not complete this block.
24i	ID Qualifier	A	Enter the two-digit ID Qualifier: **G2** = 13-digit Provider ID Number (legacy #)
24j (a)	Rendering Provider ID #	A	Complete with the **Rendering Provider's** Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total). **Note**: Only one rendering provider per claim form.
24j (b)	NPI	LB	Do not complete this block.
25	Federal Tax I.D. Number	LB	Do not complete this block.
26	Patient's Account Number	O	**Use of this block is strongly recommended**. It can contain up to ten alpha, numeric, or alphanumeric characters and can be used to enter the provider specific patient account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help the provider identify claims if an incorrect beneficiary number is listed.
27	Accept Assignment	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
28	Total Charge	LB	Do not complete this block.
29	Amount Paid	LB	Do not complete this block.
30	Reserved for NUCC Use	LB	Do not complete this block.
31	Signature of Physician or Supplier Including Degree or Credentials	M/M	This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, except for abortions, if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an 8-digit (MMDDCCYY) format (e.g. 03012004).
32	Service Facility Location Information	LB	Do not complete this block.
32a		LB	Do not complete this block.
32b		LB	Do not complete this block.
33	Billing Provider Info & Ph.#	M	Enter the billing provider's name, address, and telephone number **Do not use slashes, hyphens, or spaces.** **Note:** If services are rendered in the patient's home or facility, enter the service location of the provider's main office.
33a		A	Enter the 10-digit NPI number of the billing provider.
33b		M	Enter the 13-digit Group/Billing Provider ID number (MPI #)

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Appendix A: Financial Management Services (FMS) Edits for Fiscal Year 2009-2010 and forward. (ESCs are subject to change)

Error Status Code	Error Code Short Description	Edit
775	> One Unit Billed For Admin Fee	The Monthly Administrative Fee or One-Time Administrative Fee should only be billed with one unit. If more than one unit is billed, the claim detail will pay and cut back the claim units billed to one unit. In addition, the informational edit 775 will post, which states the following: *'> One Unit Billed For Admin Fee'*.
919	PDS Authorized Service Not Found on ISP	If there is not an authorized FMS service on the ISP, PROMISe will post ESC 919 '*PDS Authorized Service Not Found on ISP*' and your service line will be ***denied***.
5561	1 Monthly Admin Fee Allowed per Mth Per Consumer	The Monthly Administrative Fee can only be billed one per calendar month per consumer, per Local Vendor Fiscal or Agency With Choice. If more than one is billed, your claim detail (service line) will ***deny*** and ESC 5561 '*1 Monthly Admin Fee Allowed per Mth Per Consumer*' will post.
5562	Bill Monthly Admin Fee in Following Month	The Monthly Administrative Fee cannot be billed until at least the first date of the following month. If it is billed before this time, then ESC 5562 '*Bill Monthly Admin Fee in Following Month*' will post to the claim detail (service line) and your second monthly administrative fee will be ***denied***.
5563	Bill Admin Fee for Camp or Trans/Week/Consumer	Camp or Transportation Services and the One Time Administrative Fee can only be billed 1 per calendar week per claim detail. If the claim detail (service line) span equates to more than 1 calendar week, then the claim detail line (service line) will ***deny*** and ESC 5563 '*Bill Admin Fee for Camp or Trans/Week/Consumer*' will post.

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5566	Dates of Service Mismatch for Service & Admin Fee	One-Time Administrative Fee must be billed with the same dates of service as the One-Time Vendor Service billed. Payment for the One-Time Administrative Fee and Service is only made one time for dates of service that span more than a calendar week (Sunday through Saturday). **Example:** Provider bills a One-Time Admin Fee from May 19 to May 26 and bills for the Service, associated with the One-Time Admin Fee, from May 19 to May 27. The dates of service for the One-Time Admin Fee and One-Time Vendor Service **do not** exactly match in this example. As a result, the service lines for the fee and service will both ***deny*** and ESC 5566 will post. If the condition above is not met, the claim detail (service line) will ***deny*** and ESC 5566 '*Dates of Svc Mismatch for 1Time Vendor Svc & Admin*' will post.
5567	Only 1 Admin Fee & Service Per Claim	**Scenario 1**: Performed service and One-Time Administrative Fee MUST BE BILLED ON THE SAME CLAIM. If not, then the entire claim will ***deny*** and ESC 5567 '*Only 1 Admin Fee & Service Per Claim*' will post. **Scenario 2**: Performed service MUST BE BILLED FIRST ON CLAIM and the One-Time Administrative Fee MUST BE BILLED SECOND ON THE CLAIM. When the One-Time Admin Fee is listed first (instead of second) on a claim detail line (service line) and the service it applies to is listed second, then this edit will post and the entire claim will ***deny***.
5568	Service Prgm Change for Admin Fee	If the performed service is assigned as a Base Program service (WAV 14) by HCSIS (edit code E504 will be sent back to PROMISe and ESC 969 will post) and the Administrative Fee is assigned a Consolidated Service Program Code (WAV 12) or P/FDS Service Program Code (WAV 13), then the Administrative Fee will be assigned as a Base Program Service (WAV14) and Edit 5568 '*Service Program Change for Admin Fee*' will post and ***pay*** the service and Administrative Fee.

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5569	Admin Fee On Claim Suspends When Service Suspended	If the performed service on claim is suspended, the One Time Administrative Fee will post ESC 5569 '*Admin Fee On Claim Suspends When Service Suspended*' and will ***suspend*** also. Both claim details will need to be manually reviewed. The reviewer will make a determination and either force ***pay*** or force ***deny*** the claim. After a pay or deny determination is made, the claim is recycled through the claims processing system and is subject to other editing.
5570	Admin Fee On Claim Denied When Service Denied	If the performed service on the claim is denied, the One Time Administrative Fee will post ESC 5570 '*Admin Fee On Claim Denied When Service Denied*' and the One Time Admin Fee claim detail (service line) will also be ***denied***.
5572	Monthly Admin fee Cannot Span Calendar Months	Monthly Admin Fee cannot span calendar months. If it spans more than one calendar month, the claim detail (service line) will ***deny*** and ESC 5572 '*Monthly Admin Fee Cannot Span Calendar Months*' will post to the claim detail.
5573	More than 1 mthly Admin Fee billed per indiv/month	The Monthly Administrative Fee can only be billed one per calendar month per consumer per FMS organization. If another provider bills a Monthly Administrative Fee in the same month for the same consumer, then ESC 5573 '*More than 1 mthly Admin Fee billed per indiv/month'* will post to the claim detail (service line) and ***suspend***. Suspended claims require a manual review. The reviewer will make a determination and either force pay or force deny the claim. After a pay or deny determination is made, the claim is recycled through the claims processing system and is subject to other editing. This error code would typically post when a different provider takes over rendering the individual's service in the middle of the month.

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5574	Multiple Types of Admin Fees Billed in Same Month	If the same provider bills for any Admin Fee (Monthly Admin Fee (W7318/W7319), One Time Administrative Fee (W0026/W0027) and/or an Administrative Fee (W0025)) in the same month/year for the same consumer, the first Admin Fee received will pay. The second Admin Fee billed will be ***denied*** and ESC 5574 '*Multiple Types of Admin Fees Billed in Same Month*' will post. This scenario applies to different claim detail lines (service lines) within the same claim or across different claims.
5592	U4 mod not allowed w/code for Base Funded Svcs	If services are Base funded and billed in combination with a U4 modifier, the claim will ***deny*** and post 5592 '*U4 mod not allowed w/code for Base Funded Svcs*' to the claim detail (service line).
5597	Camp/Trans Admin Fee - Fiscal Year Span	No ODP services are to be billed for dates of service that span fiscal years. If camp and transportation are billed on a claim, with the admin fee, where services were rendered the last week of the fiscal year and the week spans the month of June and July, then ESC 776 will post and your claim will deny. In order to get paid, the provider should submit 2 separate claims. The first claim should include the services and admin fee for dates of service up to 6/30 and the second claim should include the service and admin fee for the dates of service for 7/1 and forward. Under normal circumstances, 2 one-time admin fees and 2 of the same service can not be billed during the same week, even on separate claims; however, the situation explained above, regarding fiscal years, is an exception. The system recognizes that the 2 one-time admin fees and 2 identical services, with the same dates of service, had fallen within a fiscal year and; therefore, allows the provider to submit the services and admin fees on 2 separate claims in order to receive payment. Informational edit 5597 will post when the scenario described above is identified by the system. This edit lets the provider know that this scenario has been recognized and will pay.

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5669	Only one Service and One Time Admin fee on a claim	When more than One Admin Fee and more than one service are submitted on the same claim, the system cannot decide which fees apply to which services. As a result, this edit will post and all the claim detail lines (service lines) for the services and the Admin Fees will deny. The provider should resubmit the services on 2 different/separate claims in order to receive payment.