CMS-1500 Tips for Billing

Page updated: September 2020

This section describes *CMS-1500* fields that must be completed accurately and completely in order to avoid claim suspense or denial. Tips below are designed to supplement instructions in the *CMS-1500* Completion section of this manual.

Common Billing Errors

Field	Description	Error
1	Medicare/Medicaid/ Other ID	Not checking appropriate box. **Billing Tip:** Enter a check mark or "X" in both the *Medicaid* and Medicare boxes when billing Medicare crossover claims.
1A	Insured's ID Number	Entering the recipient Medi-Cal ID number incorrectly. Submitting the recipient's Social Security Number (SSN). **Billing Tip:** Verify that the recipient is eligible for the services rendered by using the Point of Service network (POS network) or contacting the Automated Eligibility Verification System (AEVS). Do not enter the Medicare ID number. Use the recipient's Benefits Identification Card (BIC) number not their SSN.
19	Additional Claim Information	Reducing font size or abbreviating terminology to fit in the field. **Billing Tip:** If additional information cannot be entered completely, attach additional information to the claim. Reducing font size and abbreviating terminology may result in scanning difficulties and/or medical review denials.
23	Prior Authorization Number	Entering the Eligibility Verification Confirmation (EVC) number instead of the TAR Control Number (TCN). **Billing Tip:** The EVC number is only for verifying eligibility. Do not enter this number on the claim. Ensure that the 11-digit number entered on the claim includes both the 10-digit TCN plus the one-digit Pricing Indicator (PI) from the *Adjudication Response* (AR) notice.

‹‹Common Billing Errors (Continued)››

Field	Description	Error
24A	Date(s) of Service	Omitting the product ID qualifier and National Drug Code (NDC) from the shaded area of field 24A on claims billed for physician-administered drugs. **Billing Tip:** Check instructions in the Physician-Administered Drugs – NDC: *CMS-1500 Billing Instructions* and *CMS-1500 Completion sections* of this manual for the appropriate entry of product ID qualifier and NDC.
24B	Place of Service	Entering the wrong Place of Service two-digit code. **Billing Tip:** Check instructions in the *CMS-1500 Completion* section of this manual for the appropriate two-digit code.
24D	Procedures, Services or Supplies	Omitting modifiers or entering incorrect information when required. **Billing Tip:** Do not use Medicare modifiers. Enter procedure description, if necessary, in *Additional Claim Information* field (Box 19). <u>For physician-administered drugs:</u> Incorrect entry of optional unit of measure and numeric quantity. **Billing Tip:** Unit of measure and numeric quantity are optional; however, entering the NDC quantity in the proper format is crucial to the correct payment for a billed NDC. Check instructions in the *Physician-Administered Drugs – NDC: CMS-1500 Billing Instructions* and *CMS-1500 Completion* sections of this manual for the appropriate unit of measure qualifier values and NDC quantity format. <u>For Section 340B providers submitting claims for physician-administered drugs:</u> Omitting the modifier UD from the modifier portion (unshaded) of field 24D of the *CMS-1500*. **Billing Tip:** Check instructions in the *CMS-1500* Completion section of this manual for the appropriate location of the modifier UD for Section 340B drugs on the *CMS-1500.*

‹‹Common Billing Errors (Continued)››

Field	Description	Error
31	Signature of Physician or Supplier Including Degrees or Credentials	Submitting unsigned claims or claims with illegible signatures. Using initials or stamped signatures or signature extending outside the box. **Billing Tip:** Signatures must be written, not printed, in blue or black ink. Do not allow signature to extend outside the box. Stamps, initials or facsimiles are not acceptable.
32	Service Facility Location Information	Entering the wrong facility NPI number for the Place of Service entered in field 24B. Omitting the facility NPI when a facility-related Place of Service code is entered in field 24B. **Billing Tip:** Enter the facility NPI in Box 32A.

Attachment Reminders

Attachment	Reminder
I.V. Administration Sets	See the *Intravenous or Intra-arterial Solutions: Administration Sets* section in the appropriate Part 2 manual for billing guidance.

Field Completion Reminders

Providers should remember the following when completing the claim form.

- The “white” space on the top of the form is reserved for use by the California MMIS Fiscal Intermediary only. Type only in areas of the claim form designated as fields. Do not type in undesignated white space.
- Enter the 10-digit TCN followed by the one-digit PI from the *Adjudication Response* (AR) in the *Prior Authorization Number* field (Box 23) when applicable.
- When billing for a single date of service, enter the date the service was rendered in the “From” box in the *Dates of Service* field (Box 24A) in the six-digit format for Month, Day, Year (MMDDYY). For example, if the date of service is June 12, 2007, enter as 061207. When billing “From-Through” services, put the beginning date of service in the “From” column and the through date of service in the “to” column of Box 24A.
- Enter delay reason code “11” in the unshaded area of the EMG field (Box 24C) when the claim is over the six-month billing limit and delay reason codes “1,” “3” thru “7,” “10,” “11” or “15” do not apply. If an emergency code is listed in the unshaded area, place the delay reason code in the shaded area.
- When deleting an incorrect claim line, strike through the entire detail line from the left border of field 24A *(Dates of Service)* to the right border of the *Rendering Provider ID Number* field (Box 24J). Enter the correct billing information on another detail line. Be sure to use only a blue or black ballpoint pen. Felt-tip pens are unacceptable.

Paper Claim Form Requirements

The following paper claim form requirements and standard billing procedures can speed claim processing and prevent delays. Before submitting claims, check to see that:

- The *CMS-1500* is printed with "drop-out" ink and that the form meets CMS standards.
- The original claim is submitted. Carbon copies or photocopies, computer-generated claim form facsimiles or claim forms created on laser printers are not acceptable.
- Individual claim forms are separated. Each claim is processed separately. Do not staple original claims together. Stapling original claims together indicates the second claim is an "attachment," not an original claim to be processed separately.
- All perforated sides are removed. For accurate scanning, be sure to leave a ¼-inch border on the left and right side of the form after removing the perforated sides.
- Information is typed within the designated area of the field. Be sure the type falls completely within the white space and is properly aligned with corresponding information. If using a DOT matrix printer, do not use "draft mode." The characters do not have enough distinction and clarity for the optical character reader to accurately determine the contents.
- All dates are entered without slashes. Do not use punctuation, such as decimal point (.), dollar sign ($), positive (+) or negative (-) symbol when entering amounts.
- Attachments are taped to an 8½ x 11-inch sheet of paper with non-glare tape. Do not use original claims as attachments.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.