



## CMS Billing Instructions

### Revision Table

| <b>Revision Date</b> | <b>Sections Revised</b> | <b>Description</b>  |
|----------------------|-------------------------|---|
| 7/1/02               | All                     | Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.   |
| 3/14/05              | 2.7                     | Added instructions for billing office visit co-pays.  |
| 3/10/07              | 2.3, 2.9                | Complete revision to reflect changes made to the CMS -1500 (revision 08/05) Claim Form on Instructions for Completion. Section 2.9 added for the billing of HCPCS Drug Codes. |
| 8/30/07              | 2.2, 2.3, 2.5, 2.6, 2.7 | Clarification has been made to the billing instructions.  |
| 10/16/07             | 2.3                     | Diagnosis code directives simplified.   |
| 3/26/10              | 2.5                     | Removed obsolete wording  |



## **CMS Billing Instructions**

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## 1.0 Introduction

The Division of Medicaid & Medical Assistance (DMMA) establishes all policies and procedures governing the Delaware Medical Assistance Program (DMAP). The General Policy and Provider Specific Policy manuals are to be referenced for all program guidelines.

HPES is the DMAP Fiscal Agent. Providers are to bill HPES for the care and services rendered to medical clients.

The CMS-1500 billing instructions are designed as a reference tool to be utilized by DMAP providers when submitting claims for payment. This manual should be used in conjunction with the General Policy and Provider Specific Manuals. The submission of proper and complete billing documents by providers is essential for timely and accurate claims processing and payment.

Initially, providers should carefully read this manual to become familiar with the contents. The manual should then be referenced when completing billing documents or forms. HPES will periodically update the Billing Manual on the DMAP Web site. Providers can opt to have paper updates sent through the mail. Revised pages should be promptly inserted into the manual for quick and accurate future reference.

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## 2.0 Billing Instructions

### 2.1 Introduction

This section is for providers who bill for professional services on the CMS-1500 claim form. A separate form is required for billing the services provided to each client.

The provider should carefully read and adhere to the following instructions so that claims can be processed efficiently. Accuracy, completeness, and clarity are important.

### 2.2 General Procedures

Verify eligibility through the Voice Response System (VRS), Internet, Provider Electronic Solutions or swipe card reader.

- File claims within time limits specified in the General Policy Section of this manual.
- Use only original CMS-1500 forms with red drop-out ink.
- Include only what is required in Section 2.3 (e.g., no stickers, no stamps, no unnecessary handwritten comments).
- Ensure that all claims submitted for Medical Assistance payment are signed in black ink or a signed Trading Partner Agreement is on file at HPES.
- Ensure that handwritten claims are completed using black ink.
- Ensure that all required inclusions are submitted, e.g., Explanation of Medical Benefits (EOMB) from third-party insurance coverage.
- Mail the completed claims to the following address:

**HP Enterprise Services, LLC**

**P.O. Box 909, Manor Branch**

**New Castle, DE 19720-0909**

### 2.3 Completion of the CMS-1500

This section provides specific instructions for completing the CMS-1500 claim form for the Delaware Medical Assistance Program. The numbered items correspond to numbered fields on the claim form. Ditto marks (" ") are not allowed to reference the information on the preceding line.

| Field Number | Name                                   | Instructions for Completion   |
|--------------|--|---|
| 1            |  | Check the Medicaid block at the top of the form   |
| 1 a          | Insured's ID                           | Enter the entire 10-digit Medicaid client identification number.  |
| 2            | Patient's Name                         | Enter the client's last name, first name, then middle initial   |
| 3            | Patient's Date of Birth                | Enter the client's date of birth in month, day and year (MMDDYY) format   |
|              | Patient's Sex                          | Check M for male; F for female  |
| 4            | Insured's Name                         | Not required  |
| 5            | Patient's Address                      | This is an optional field. Enter the client's address and specify the street, city, state and zip code. The telephone number also may be included, if available.  |
| 6            | Patient's Relationship to Insured      | Check the block marked Self.  |
| 7            | Insured's Address                      | Not required  |
| 8            | Patient Status                         | Check single, married or other. If employed or a full or part time student, check accordingly   |
| 9            | Other Insured's Name                   | If there is any other applicable third party insurance, enter the name of the policyholder  |
| 9 a          | Other Insured's Policy or Group Number | Enter the applicable policy or group number   |
| 9 b          | Other Insured's Date of Birth          | Not required  |
| 9 c          | Employer's Name or School Name         | Enter the appropriate information, if applicable.   |
| 9 d          | Insurance Plan or Program Name         | The plan name is optional but the NEIC code is required. The EOB or remittance from the third party carrier must be included with your claim before payment can be made. The client should be questioned to determine if other coverage is carried  |
| 10           | Was Condition Related To:              | a. Employment - Check Yes if the client's condition was employment related. If the condition was not employment related, check No.<br>b. Auto Accident - Check the appropriate box if the client's condition was auto accident related. Leave blank if condition was not auto accident related. |

| <b>Field Number</b> | <b>Name</b>  | <b>Instructions for Completion</b>   |
|---------------------|--|--|
|                     |  | c. Other Accident - Check the appropriate box if the client's condition was an accident other than auto related. Leave blank if the condition was not accident related.  |
| 10 d                | Reserved for Local Use                                 | Not required   |
| 11                  | Insured's Policy Group or FECA Number                  | Not required   |
| 11 a                | Insured's Date of Birth                                | Not required   |
| 11 b                | Insured's Employer or School Name                      | Not required   |
| 11 c                | Insured's Insurance Plan or Program Name               | Not required   |
| 11 d                | Is There Another Health Benefit Plan?                  | If the answer is yes, please complete item 9 a-d.  |
| 12                  | Patient's or Authorized Person's Signature             | Not required   |
| 13                  | Insured's or Authorized Person's Signature             | Not required   |
| 14                  | Date of Current  | Not required   |
| 15                  | If Patient has had Same or Similar Illness             | Not required   |
| 16                  | Dates Patient was Unable to Work in Current Occupation | Not required   |
| 17                  | Name of Referring Physician or Other Sources           | If applicable, enter the name of the referring physician   |
| 17 a                | Other  | Leave Blank  |
| 17 b                | NPI  | Enter the 10 digit NPI or 10 digit Atypical number   |
| 18                  | Hospitalization Dates Related to Current Services      | Not required   |
| 19                  | Reserved for Local Use                                 | Utilize this section for any remarks or comments regarding the claim.  |
| 20                  | Outside Lab  | If applicable, indicate Yes if the client had outside lab work completed. Otherwise, leave blank   |
| 21                  | Diagnosis  | Enter the diagnosis code. Up to four diagnosis codes may be entered with the primary diagnosis listed first and the secondary listed second. Relate diagnosis number (1-4) to Item 24e by line. A diagnosis code is required based on the procedure. |
| 22                  | Medicaid Resubmission                                  | Not required   |
| 23                  | Prior Authorization                                    | If applicable, enter the 8-digit prior authorization number assigned by DMAP   |
| 24 A                | Dates of Service                                       | Enter the date of service for each service provided in MMDDYY format. Each date of service must be   |

| <b>Field Number</b> | <b>Name</b>                                      | <b>Instructions for Completion</b>   |
|---------------------|--|--|
|                     |  | billed on a separate detail line when billing with procedure codes. Exceptions: Multiple-day service codes, and codes requiring an RR modifier.  |
| 24 B                | Place of Service                                 | Enter the appropriate 2-digit place of service code  |
| 24 C                | EMG  | Not required   |
| 24 D                | Description of Procedures, Services, or Supplies | Enter the HCPCS procedure code and modifier, if applicable, which best describes the services rendered. Refer to the Provider Specific Section of your manual for special HCPCS codes that are valid for Delaware. Refer to section 2.9 for HCPCS Drug codes.                                      |
| 24 E                | Diagnosis Pointer                                | Enter the diagnosis pointer 1-4 to refer to a diagnosis code in field 21.  |
| 24 F                | Charges  | Enter the charge for the rendered service. This charge should be the providers' current usual and customary fee to private patients. If more than one unit of service is being billed, enter the charge for all units billed.  |
| 24 G                | Days or Units                                    | Enter the days or units of service rendered as a whole number  |
| 24 H                | EPSDT/Family Planning                            | Indicate Y for yes if the patient is part of the EPSDT program. Otherwise, leave blank.  |
| 24 I                | ID. Qual./NPI                                    | Not required   |
| 24 J                | Rendering Provider ID                            | Enter the 10 digit NPI or Atypical number  |
| 25                  | Federal Tax ID #                                 | Not required   |
| 26                  | Patient's Account Number                         | An optional entry that the provider may use for accounting purposes. Enter the client's account number, if applicable. Up to 20 numeric or alphabetic characters will be accepted. The number will appear on the Remittance Advice as this is a way of identifying payment of claims.              |
| 27                  | Accept Assignment                                | Not required   |
| 28                  | Total Charges                                    | Enter the total of Column 24F. This block should contain a sum of charges for all services indicated on the claim form.  |
| 29                  | Amount Paid                                      | Enter the total amount of funds received from third party insurance sources, other than Medicare.  |
| 30                  | Balance Due                                      | Enter the net charge. This amount is obtained by subtracting the amount received from other sources (Field 29) from the total charge (Field 28).   |
| 31                  | Physician's or Supplier's Signature              | The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by him or under his direction. Provider's signature is defined as the provider's actual signature or the signature of an individual authorized by the provider |

| Field Number | Name                                  | Instructions for Completion  |
|--------------|---------------------------------------|--|
|              |                                       | rendering the service. The name of a clinic or group is not acceptable. Rubber stamp or facsimile signatures are not acceptable. The signature must be in black ink. Required. |
| 32           | Service Facility Location Information | Enter the name and address specifying the street, city, state and zip code of the facility where services were performed if other than home or office.                         |
| 32 a         | NPI                                   | Not required   |
| 32 b         | Other                                 | Leave blank  |
| 33           | Billing Provider Info & Phone Number  | Enter the provider's name, complete address and telephone number.  |
| 33 a         | NPI                                   | Enter the 10 digit NPI or Atypical number  |
| 33 b         | Other                                 | Leave blank  |

## 2.4 CMS-1500 Claim Form

The Centers for Medicare & Medicaid Services (CMS) is responsible for the CMS-1500 form.

Optical Character Recognition (OCR) equipment is utilized in Delaware to process paper claims. The provider must submit these forms using the scannable, red ink version of the CMS-1500. Please contact the U.S. Government Printing Office at (202) 512-1800 or your local Medicare carrier.

## 2.5 Inclusions

When a client has third party insurance coverage, you must include a copy of the EOB or remittance from the third party insurance carrier. If the carrier denied the claim, you must include the denial EOB or remittance to show you have filed the claim.

## 2.6 Completion of Medicare/Medicaid Related Claims for CMS-1500

If medical services are provided to a client who is entitled to Medicare under the Social Security Act and also to Medicaid benefits, it is necessary that you file a claim with Medicare first. After you receive payment from Medicare, you may file a claim to Medicaid for reimbursement consideration. Each performing provider's services must be billed on a separate claim form to Medicare in order to file a Medicare/Medicaid related claim to HPES.

In order to submit a Medicare/Medicaid claim to HPES, you must submit an original CMS-1500 claim with the following fields altered from your Medicare claim:

- Field 1a - complete this field with the client's identification number;
- Field 24J - complete this field with the performing provider's NPI or Atypical number;
- Field 29 - do not enter the Medicare Paid Amount. Enter only the total amount of funds received from third party

insurance sources, other than Medicare; and,

- Field 31 - each claim must be signed with an original black ink signature;
- Field 33a - complete this field with the billing provider's NPI or Atypical number.

You must include a copy of the Medicare EOMB to the claim with the client's name circled. Each Medicare/Medicaid client listed on the EOMB must have a separate claim filed with an EOMB included with their claim form.

Any charges denied by Medicare will not be paid by Medicaid with the exception of:

those services not covered by Medicare but covered by Medicaid; or

services covered by both Medicare and Medicaid but with different limits or criteria. In these instances Medicaid will determine coverage on the basis of its own policy.

You must include a copy of the Medicare EOMB to the claim with the client's name circled. Each Medicare/Medicaid client listed on the EOMB must have a separate claim filed with an EOMB included with his or her claim form. Each performing provider's services must be billed on a separate claim form with a maximum of six lines and no double details in one box.

## **2.7 Billing for Office Visit Co-Pays**

To submit a claim for an office visit co-pay the following fields need to be completed:

- Field 24D – Enter the procedure code for the office visit
- Field 24F – Enter the amount of the co-pay
- Field 28 – Enter the amount of the co-pay
- Field 29 – Leave blank

A copy of the TPL voucher must be included. On the voucher, indicate the column that shows the co-pay or patient responsibility amount.

Providers who bill electronically would follow the same procedures by completing the Procedure Code and Billed Amount fields. In the Other Insurance Reason Code field, fill in the appropriate code for co-pay billing.

## **2.8 Out-of-State Providers**

Out-of-State providers must bill the Delaware Medical Assistance Program following the instructions outlined in this manual.

## **2.9 Billing of HCPCS Drug Codes**

To submit a claim for a HCPCS Drug Code, complete field 24 as follows:

- Field 24D – Enter the HCPCS Drug Code in the primary field (bottom),
- In the supplemental field (top shaded area) enter the appropriate NDC code(s) as follows:

- Maximum of three NDCs per drug code
- Qualifier N4 must precede each NDC
- Enter NDC information in field 24D through field 24H
- No space, hyphen or other separator should be entered between the qualifier and the NDC number. Example: N42222222222
- Each qualifier + NDC code must be separated by a space or comma  
Example: N42222222222 N466666666666 N488888888888 or  
N42222222222,N466666666666,N488888888888