HP Enterprise Services

Nevada Medicaid and Nevada Check Up

CMS-1500 Claim Form Instructions

Nevada Medicaid Management Information System (NV MMIS)

State of Nevada
Department of Health and Human Services (DHHS)
Division of Health Care Financing and Policy (DHCFP)

Version 1.0
October 10, 2011

Change history

Date (mm/dd/yyyy)	Description of changes	Impact
11/1/2007	Provider types 25, 38, 41, 48, 57 and 58 must complete Field 17 for EPSDT referrals. Fields 24A and 24D are affected by new National Drug Code (NDC) requirements. Field 24H is now marked Conditional as it applies to family planning service providers only. Field 32a is now marked Recommended, as the NPI of the service location is not required for claims processing.	Instructions have changed for Fields 17, 24A, 24D, 24H and 32a.
11/19/2008	While most providers bill their usual and customary charge in this field, the Medicaid Services Manual (MSM) specifies that certain services must be billed based on other criteria (e.g., physician administered drugs must be billed at the Average Wholesale Price (AWP) and per MSM Chapter 300, radiopharmaceuticals must be billed at 100 percent of wholesale invoice price). It is important to be familiar with the MSM chapters that apply to the services you provide. The field requirement for Field 32 has changed from Required to Conditional. Some services are provided in the recipient's home and therefore do not require a servicing facility address. The field requirement for Field 32a has been changed from Required to Not Required as this information is not required in order to process the claim	Instructions have changed for Field 24F.
12/29/2008	Field 33b is now labeled as Conditional instead of required. API users must complete this field, but it is required for NPI users only when they use a taxonomy code.	Field 33b
4/1/2010	These fields are no longer required. EPSDT services are identified by EP or TS modifiers used in Field 24D. Rendering provider information is recorded in Field 24J	Instructions have changed for Fields 17 and 17a.
10/01/2011	Takeover HP	All

Table of contents

CMS-1500 field requirements 1
- Required 1
- Conditional 1
- Recommended 1
- Not required 1
- Spaces, dashes and hyphens 1

Audience 1
Questions? 2
Claims mailing address 2
Billing Manual 2
Provider training 2
Web announcements 3
Adjustment/Void reason codes for Field 22 3
- Adjustment reason codes 3
- Void Reason Codes 4

Instructions for completing Form CMS-1500 (08/05) 5
- CMS 1500 field requirements 6

CMS-1500 field requirements

Required

Fields marked *Required* in the claim form instructions must be completed on all paper claim submissions. The claim may be denied if a *required* field is incomplete.

Conditional

Fields marked *Conditional* are required when they apply to the claim. For example, Field 9a (marked *Conditional*) must be populated with the policy or group number only when TPL applies.

Recommended

Fields marked *Recommended* are not required, but will be returned with the provider's remittance advice if supplied on the claim. For example, if the provider's in-house, patient account number is provided in Field 26, it will be returned on the remittance advice, thereby allowing billing staff to cross reference the claim with the provider's records if needed.

Not required

Fields marked *Not Required* are not used in processing the claim, although the provider is free to populate the field if desired.

Spaces, dashes and hyphens

Do not enter spaces, dashes, hyphens or any other kind of punctuation within a provider's NPI/API or 9-digit ZIP code, a recipient's ID, or any other identifier on the claim.

Audience

These instructions address requirements for Nevada Medicaid claims submitted on paper.

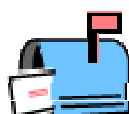
For electronic claim field requirements, please see the HP Enterprise Services Companion Guides.

Questions?

If you have any questions, please call the Customer Service Center at (877) 638-3472.

Claims mailing address

Use only claim forms with red drop-out ink. Keep the yellow (bottom) copy for your records and mail the white (top copy) to:



HP Enterprise Services
CMS-1500
PO Box 30042
Reno, NV 89520-3042

Adjustments, voids and any other written correspondence may also be sent to this address.

Billing Manual

Please be familiar with information in the Billing Manual as it is your reference guide for interfacing with Nevada Medicaid and HP Enterprise Services. The Billing Manual is updated regularly and includes important claims/billing topics such as:

- Adjustments and voids
- Attachments
- Fixing mistakes on a claim
- Submitting clean paper claims
- Timely filing

Provider training

HP Enterprise Services and the Division of Health Care Financing and Policy (DHCFP) offer free training classes throughout the year.

The Provider Training Catalog lists class schedules, descriptions and more.

We encourage the attendance of billing staff, billing agencies, direct practitioners/ health care providers, office managers, admitting and front desk staff, etc.

If you have questions or comments regarding training, contact the HP Enterprise Services Provider Training Unit at:

Phone: (877) 638-3472 (When calling, press the option for Provider Enrollment, then ask for the Training Unit.)

Email: nvmmistraining@hp.com

Web announcements

On average, HP Enterprise Services releases two new Web announcements per week. Many pertain directly to billing practices. Each announcement appears on the Home page at https://medicaid.nv.gov/ before being archived on the Announcements/Newsletters webpage. Be sure to check this website at least weekly for these important updates.

Adjustment/Void reason codes for Field 22

To adjust or void a *previously paid* claim, use an adjustment or void reason code to complete the *CODE* area of Field 22 (MEDICAID RESUBMISSION). Resubmitting a *denied* claim is not considered an adjustment or void.

Adjustment reason codes

Use one of the following codes in Field 22 when adjusting a previously paid claim.

Code	Adjustment Reason	Code	Adjustment Reason
1000	Case adjusted readmission	**1031**	Correcting units, visits, studies and/or procedure code
1001	Case adjusted interim claim case building	**1032**	IC reconsideration of allowance, documented
1002	Case adjusted implied transfer	**1033**	Correction to admitting, referring, prescribing provider adjust ID
1003	Case adjusted TPL on interim bill is 113 or 114	**1034**	Correcting quantity dispensed
1005	Non-group able claim void	**1035**	Correcting drug code
1010	Credit balance process	**1036**	Allowance for prescription less than provider cost
1011	Overpayment identified by TPL contractor	**1037**	Services not covered by Medicare
1012	Partial payment by primary health insurance	**1038**	Correcting tooth code
1021	Late charges received by facility business office	**1039**	Correcting site code
1022	Credit received by facility billing department	**1040**	Correcting wait time/# of passengers/miles
1023	Primary carrier has made additional payment	**1041**	Incorrect amount paid for original claim
1024	Primary carrier has denied full payment	**1042**	Original claim has multiple incorrect items
1025	Accommodation charge correction	**1043**	Correcting an error made by data entry
1026	Patient-payment amount charged	**1053**	Adjustment (miscellaneous)
1027	Correcting service period/dates	**1054**	Partial payment by liability insurance
1028	Correcting procedure/service code	**1055**	Claim payment changed due to relationship of this procedure to another procedure
1029	Correcting diagnosis code	**1057**	Purpose of submitting not clear
1030	Correcting charges	**1058**	Adjusted for recovery of overpayment

Void Reason Codes

Use one of the following codes in Field 22 when voiding a previously paid claim.

Code	Void Description	Code	Void Description
1013	DHP license not renewed	**1052**	Void reason is in miscellaneous category
1020	Voided 21 in 60 limit exceeded	**1056**	Services covered under total OB care
1044	Wrong Provider ID used by billing clerk	**1059**	Voids/Conflicts with previously paid claim
1045	Wrong recipient ID used by billing clerk	**1060**	Other insurance is available
1046	Primary carrier paid Medicaid max allowance	**1070**	Transplant charges, bill hospital
1047	Duplicate payment	**1071**	Included in ER visit payment
1048	Primary carrier has paid full charges	**1072**	Newborn/Mother in MCO, bill MCO
1049	Recipient not eligible	**1073**	Credit balance process
1050	Services not covered	**1074**	Overpayment-TPL contractor
1051	Recipient not patient of provider	**1075**	Void resulted from UR review by agency

Instructions for completing Form CMS-1500 (08/05)

The CMS-1500 (08/05) claim form is shown below with Nevada Medicaid *Required* fields shaded red, *Conditional* fields shaded blue, and *Recommended* fields shaded yellow. (On a non-color print-out, *Required* fields will appear darkest.)

1500

HEALTH INSURANCE CLAIM FORM

Nevada Medicaid Field Requirements
Effective April 1, 2010
Change to Fields 17 and 17a

CARRIER

PATIENT AND INSURED INFORMATION

1a

2

3

9

9a

9b

9c

9d

10

11

11a

11b

11c

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

14

17 NAME OF REFERRING PROVIDER OR OTHER SOURCE

19

20

21

22

23

Fields 24: A B D E F G H I J

2

3

4

5

6

PHYSICIAN OR SUPPLIER INFORMATION

25

26

27 ACCEPT ASSIGNMENT?

28

29

30

31

32

33

33a

33b

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CMS 1500 field requirements

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
1	Not required	Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other
1a	**Required**	**Insured's ID number:** Enter the recipient's 11-digit Recipient ID (Enrollee ID) as shown on their Medicaid card.
2	**Required**	**Patient's name:** Enter recipient's full last name, first name and middle initial (Enrollee Name) as printed on their Medicaid card. If the recipient uses a last name suffix (e.g., Jr, Sr), enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, and Dr) and professional suffixes (e.g., PhD, MD, and Esq.) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.
3	**Required**	**Patient's birth date, sex:** Enter the recipient's birth date in MM DD CCYY format. Enter an X in the correct box to indicate the recipient's gender.
4	Not required	Insured's name
5	Not required	Patient's Address, City, State, Zip Code, Telephone
6	Not required	Patient relationship to insured
7	Not required	Insured's Address, City, State, Zip Code, Telephone
8	Not required	Patient status
If recipient has Medicare coverage, Medicare information must entered in Fields 9a and 9d. If Medicare is secondary, enter primary carrier information in Fields 11 and 11c.		
9	Not required	Other insured's name
9a	**Conditional**	**Other insured's policy or group number:** *Recipient has TPL with* ***Medicare*** *coverage:* Enter the recipient's Medicare number. *Recipient has TPL—****non-Medicare*** *coverage:* Enter the recipient's identifier with their primary carrier.
9b	Not required	Other insured's date of birth, sex
9c	Not required	Employer's name or school name

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
9d	**Conditional**	**Insurance plan name or program name:** *Recipient has* ***Medicare*** *coverage:* Enter the word *Medicare* followed by the Medicare plan name (e.g., Medicare Senior Dimensions, Medicare Senior Care Plus). *Recipient has TPL—****non-Medicare*** *coverage:* Enter the name of the primary carrier.
10a–c	**Conditional**	**Is patient's condition related to:** If the recipient's condition is a result of a work-related circumstance/occurrence, an automobile accident or other type of accident, check *YES* on the appropriate line.
10d	Not required	Reserved for local use
11	**Conditional**	**Insured's policy group or FECA number:** *Recipient has Two Forms of TPL—No Medicare:* Enter the policy number of the secondary carrier. *Recipient's Secondary Carrier is Medicare:* Enter the policy number of the primary carrier. (Medicare information is entered in Fields 9–9d).
11a	Not required	Insured's date of birth, sex
11b	Not required	Employer's name or school name
11c	**Conditional**	**Insurance plan name or program name:** **Recipient has Two Forms of TPL—No Medicare:** Enter the name of the recipient's secondary carrier. **Recipient's Secondary Carrier is Medicare:** Enter the name of the primary carrier (Medicare information is entered in Fields 9–9d).
11d	Not required	Is there another health benefit plan?
12	Not required	Patient's or authorized person's signature
13	Not required	Insured's or authorized person's signature
14	**Conditional**	**Date of current: illness, injury, pregnancy** Enter the date (MM DD YY format) if any of the following are applicable: • For services **related to an illness**, enter the date that the first symptoms occurred. • For **injury-related** services, enter the date of the accident. • For **chiropractic** services, enter the date of the first treatment. • For **pregnancy-related** services, enter the date of the first day of the woman's last menstrual period (LMP).
15	Not required	If patient has had same or similar illness

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
16	Not required	Dates patient unable to work in current occupation
17	Not required	Name of referring provider or other source
17a	Not required	Not labeled
17b	Not required	NPI
18	Not required	Hospitalization dates related to current services
19	**Conditional**	**Reserved for local use:** *Laboratory services:* Enter the provider's CLIA number. *Anesthesia services:* Enter the total minutes of reportable anesthesia time. *All Other Providers:* Leave this field blank.
20	Not required	Outside lab? $charges
21	**Conditional**	**Diagnosis or nature of illness or injury:** *Waiver, Personal Care Service and Adult Day Health Care Providers (provider types 30, 38, 39, 48, 57, 58, 83 and 84):* Leave this field blank. *All Other Providers:* Enter up to four ICD-9 codes on the lines numbered 1–4.
22	**Conditional**	**Medicaid resubmission:** Complete this field to adjust or void a previously paid claim. Otherwise, leave this field blank. In the *Code* area, enter an adjustment or void reason code (see section, *Adjustment/Void Reason Codes for Field 22*). In the *Original Reference Number* area, enter the last *paid* Internal Control Number (ICN) of the claim. **Adjustments and voids apply to previously *paid* claims only (including zero paid claims). Resubmitting a denied claim is not considered an adjustment.** *Physician-administered drugs:* Beginning January 1, 2007, adjustments for claims with **physician-administered drugs** require the use of the drug's NDC (see instructions for Fields 24A and 24D) even if the claim was originally submitted with a HCPCS code prior to January 1, 2007.
23	**Conditional**	**Prior authorization number:** If you obtained authorization for an item on this claim, enter your 11-digit Authorization Number in this field without hyphens, dashes, spaces, etc. **Enter only one Authorization Number per claim form. Complete additional forms if needed.**

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
There are 6 numbered claim lines on the CMS-1500 form, each with a top, shaded half and a bottom, white half. Each procedure, service, supply and drug must be listed on its own claim line (1-6). For example, do not use the top, shaded half of a claim line to bill a physician-administered drug and the bottom, white half of the same claim line to bill an office visit. Use multiple forms if necessary to report all services provided. TPL claims, including Medicare crossover claims, may contain only one completed claim line per claim form.		
24A	**Required**	**Date(s) of service:** *Dates:* In the **bottom, white half** of the claim line, enter the begin *(From)* and end *(To)* dates of service in MM DD YY format. If a service was provided on one day only, enter the same date twice. *Physician Administered Drugs:* Beginning January 1, 2008, an NDC is required in this field to bill for physician administered drugs. In the **top, shaded half** of the claim line, enter qualifier N4 followed by the drug's **11-digit NDC without any dashes**, hyphens or other punctuation. The first, second and third sections of the NDC (separated by hyphens on the container label) must contain 5, 4 and 2 digits, respectively, when entered on the claim form. To facilitate this, you **must add leading zeros** to one or more sections of the NDC if the container label does not display: • 5 digits in the first section of the NDC • 4 digits in the second section of the NDC • 2 digits in the third section of the NDC **For example**, using the 5-4-2 model described above: • 34-73-1 on the container label is expressed as 00034007301 on the claim • 654-3773-22 on the container label is expressed as 00654377322 on the claim • 1645-222-65 on the container label is expressed as 16457022265 on the claim • 12345-6-7 on the container label is expressed as 12345000607 on the claim • 86541-4885-77 on the container label is expressed as 86541488577 on the claim For **multi-ingredient compounds**, list each component separately, on its own claim line with the 11-digit NDC is this field. For more information and examples on billing physician administered drugs, see the NDC Billing Reference on the HP Enterprise Services website.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
24B	**Required**	**Place of service:** Use the most recent CPT/HCPCS coding manual to enter the appropriate Place of Service code in the **bottom, white half** of the claim line.
24C	Not required	EMG
24D	**Required**	**Procedures, services, or supplies CPT/HCPCS modifier:** *CPT/HCPCS Code:* Enter *one* CPT or *one* HCPCS code and up to four modifiers on the **bottom, white half** of the claim line. **Effective January 1, 2008**, Medicaid does not require CPT/HCPCS codes when billing for physician administered drugs. **If the recipient has TPL (including Medicare), use the same HCPCS code and modifier(s) for all payors.** *Physician Administered Drugs:* Beginning January 1, 2008, an NDC quantity is required when billing for physician administered drugs. In the **top, shaded half** of the claim line, enter the NDC quantity i.e., the number of NDC units administered. Fractions of a unit should be expressed in decimal form using up to three decimal places. **Do not include the NDC standard unit of measure** on your claim i.e., *milliliters, grams* or *each*. **Medicare will** continue and **other payors may** continue to require HCPCS codes and units on claims post January 1, 2008. On TPL and Medicare crossover claims, enter the drug's HCPCS code and units in the **bottom, white half** of the claim line and NDC and NDC quantity on the **top, shaded half** of the same claim line.
24E	**Conditional**	**Diagnosis pointer:** In the **bottom, white half** of the claim line, enter the line number(s) of the diagnosis code in Field 21 that relates to the CPT/HCPCS code on this claim line. **Waiver Program** providers (provider types 38, 48, 57 and 58), **Personal Care Services** providers (provider types 30, 83 and 84), and **Adult Day Health Care** providers (provider type 39) may **leave this field blank**.
24F	**Required**	**$ Charges:** In the **bottom, white half** of the claim line, enter your usual and customary charge for the CPT/HCPCS/NDC on this claim line unless otherwise directed by Medicaid policy (e.g. physician administered drugs are billed at the **Average Wholesale Price (AWP)** and per MSM Chapter 300, radiopharmaceuticals are billed at 100% of **wholesale invoice price**).
24G	**Required**	**Days or units:** In the **bottom, white half** of the claim line, enter the number of days or the number of units being billed.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
24H	**Conditional**	**EPSDT/family plan:** *For providers that bill Family Planning services:* In the **bottom, white half** of the claim line, enter *Y* if services were Family Planning and *N* if they were not. **EPSDT services are identified by EP or TS modifiers used in Field 24D.**
24I	**Required**	**ID qualifier:** *Using **NPI** in Field 24J:* Enter *ZZ* in the **top, shaded half** of the claim line. *Using **API** in Field 24J:* Enter *N5* in the **top, shaded half** of the claim line.
24J	**Required**	**Rendering provider ID#:** *NPI Users:* Enter the provider's taxonomy code in the **top, shaded half** of the claim line. Enter the provider's NPI in the **bottom, white half** of the claim line. *API Users:* Enter the provider's API in the **top, shaded half** of the claim line.
25	**Required**	**Federal tax ID number:** Enter the billing provider's Social Security Number (SSN) or Employer Identification Number (EIN). Enter an X in the appropriate box to indicate which number is being reported. Only one box can be marked.
26	**Recommended**	**Patient's account number:** Enter up to 17 alpha-numeric characters for your internal patient account number. If entered, this information will be returned to you on your remittance advice.
27	Not required	Accept assignment?
28	**Required**	**Total charge:** Add all amounts in column 24F. Enter the total in this field.
29	**Conditional**	**Amount paid:** If the recipient has TPL, enter the amount paid by all other carriers, including Medicare, for the HCPCS/CPT and/or NDC on this claim form. Do not enter the amount received for *all* services on your EOB, and do not include write-off or contractual adjustment amounts. For providers with capitated agreements, enter the contract amount minus co-pay. A zero paid amount is not acceptable.
30	**Required**	**Balance due:** *Medicaid is primary coverage:* enter the amount shown in field 28. *Recipient has TPL (including Medicare):* enter the recipient's legal obligation to pay. Do not include write-off, contractual adjustment or behavioral health reduction amounts.
31	**Required**	**Signature of physician or supplier:** The billing provider or authorized representative must sign and date this field. Original, rubber stamp and electronic signatures are accepted.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
32	**Conditional**	**Service facility location information:** Enter the name and **full address** of the location where service was rendered (9-digit zip code is required—do not use spaces, dashes, hyphens, etc.). If the service was rendered in the recipient's home, leave this field blank. **Ambulance providers:** Do not enter *From* and *To* dates in this field.
32a	Not required	NPI#
32b	Not required	Other ID#
33	**Required**	**Billing Provider Info & Ph#:** Enter the billing provider's phone number to the right of this field's name. Enter the full address below the field name and phone number (9-digit zip code is required—do not use spaces, dashes, hyphens, etc.).
33a	**Required**	**NPI#:** *NPI-eligible Providers:* Enter the billing provider's NPI.
33b	**Conditional**	**Other ID#:** *API Users:* Enter *N5* followed by the billing provider's API. *NPI Users:* Enter *ZZ* followed by a taxonomy code when available. Do not use spaces, hyphens, dashes, commas, etc. in this field. For example, N51234567899 (for API user) and ZZ1234567899 (for NPI user).