
CMS-1500 Billing Guide for PROMISe™ Office of Developmental Program (ODP) Base Services & P/FDS & Consolidated Waiver Services

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:

- **Office of Developmental Programs (ODP) Base, P/FDS & Consolidated Waiver**

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.
 - **-** – 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.

Ordering and Prescribing

The Patient Protection and Affordable Care Act (ACA) added requirements for provider screening and enrollment, including a requirement that states require physicians and other practitioners who order or refer items or services for MA beneficiaries to enroll as MA providers. The Department of Health and Human Services regulation implementing this requirement can be found at 42 CFR § 455.410.

Claims submitted by the following provider types and specialties must include the NPI of a MA enrolled ordering or prescribing provider:

03 Extended Care Facility

05 Home Health Agency

16 Nurse

17 Therapist

24 Pharmacy

25 Durable Medical Equipment & Medical Supplies

Providers should check block 17, 17a, and 17b for further direction.

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Special Notes TSM (**T1017**) and Waiver Case Management Services (**W7210**) may not be billed directly through PROMISe™. These must be billed through HCSIS.

PROMISe™ providers must submit original CMS-1500 Claim Form (invoice) for processing. **Photocopies of the CMS-1500 are not acceptable and will not be processed.**

When a photocopy is received, the mailroom will attach a letter to the CMS-1500 and return it to the provider with a letter explaining that a billable service(s) must be submitted on an original claim form.

* **Please see Appendix A** (beginning on page 13 of this document) for specific billing related instructions related to Fiscal Year 2009-2010 Residential services (provider type 52).

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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 county negotiated rate is sixty-five dollars and you enter 65, your county negotiated rate may be read as .65 cents.*
- Example #1:** When completing Block 24F, enter the units multiplied by the rate, which are both found on your Service Authorization Notice. You must include the dollars and cents in the appropriate fields as seen below. Do not include a decimal point in the \$Charges block.

24F	
\$CHARGES	
35	00

- Example #2:** When completing Block 29, you are reporting the Consumer contribution to Room and Board for ineligible Residential Services. Enter the Consumer contribution as follows, including dollars and cents:

29	
Amount Paid	
50	00

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You must follow these instructions to complete the CMS-1500 claim when billing the Department of Public Welfare. **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. Note: If an X is not placed in the Medicaid box, your claim will not be processed.
1a	Insured's ID Number	M	Enter the 10-digit recipient number found on the recipient's ACCESS card. If the recipient number is not available, access the Eligibility Verification System (EVS) by using the recipient's Social Security Number (SSN) and date of birth (DOB). The EVS response will provide the 10-digit recipient number to use for this block. * See Appendix A for the Recipient ID number to enter in this block for Unplanned Permanent Vacancies.
2	Patient's Name	O	Enter the recipient's last name, first name, and middle initial.
3	Patient's Birthdate and Sex	LB	Do not complete this block.
4	Insured's Name	LB	Do not complete this block.
5	Patient's Address	LB	Do not complete this block.
6	Patient's Relationship to the Insured	LB	Do not complete this block.
7	Insured's Address	LB	Do not complete this block.
8	Patient Status	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 and Group Number	LB	Do not complete this block.
9b	Other Insured's Date of Birth and Sex	LB	Do not complete this block.
9c	Employer's Name or School Name	LB	Do not complete this block.
9d	Insurance Plan Name or Group Name	LB	Do not complete this block.
10a–10c	Is Patient's Condition Related To:	LB	Do not complete this block.
10d	Reserved For Local Use	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	Employer's Name or School Name	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 recipient's signature or the words Signature Exception must appear in this field. Also, enter the date of claim submission in an eight-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.) Please refer to Section 6 of the Handbook for the 837 Professional/CMS 1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	LB	Do not complete this block.
14	Date of Current:	LB	Do not complete this block.
15	If Patient Has Had Same or Similar Illness	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 Physician or Other Source	A	For the following provider types/specialties, you must enter the name of the MA enrolled ordering or prescribing provider. 03 Extended Care Facility 05 Home Health Agency 16 Nurse 17 Therapist 24 Pharmacy 25 Durable Medical Equipment & Medical Supplies 59-173 Speech and Language Therapy Services

17a	I.D. Number of Referring Physician	A	Enter the license number of the MA enrolled ordering or prescribing provider listed in block 17.
17b	NPI #	A	Enter the NPI of the MA enrolled ordering or prescribing provider listed in block 17. 03 Extended Care Facility 05 Home Health Agency 16 Nurse 17 Therapist 24 Pharmacy 25 Durable Medical Equipment & Medical Supplies
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.
19	Reserved For Local Use	A	Do not complete this block.
20	Outside Lab?	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	Enter the most specific three-, four-, or five-digit ICD-9-CM code that describes the diagnosis. The primary ICD-9-CM code block (21.1) must be completed. The second, third, and fourth diagnosis codes must be completed if applicable.
22	Medicaid Resubmission	A/A	This block has two uses: 1) 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) 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 <u>LAST APPROVED</u> 13-digit ICN, a space and the two-digit line number from the RA Statement in the right portion of the block (e.g., ADJ 1103123523123 01).

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Block No.	Block Name	Block Code	Notes
23	Prior Authorization Number	A	<p>Enter the 10-digit PROMISe authorization number in this field for Eligible and Ineligible Unplanned Permanent Vacancies (W7056 and W7030). For all other ODP services, leave blank.</p> <p>* Please see Appendix A (beginning on page 13 of this document) for additional billing information regarding unplanned Permanent Vacancy (procedure codes W7056 & W7030).</p>
24a	Dates of Service	M/M	<p>Enter the applicable date(s) of service.</p> <p>If billing for a service that was provided on one day only, complete either the From or the To column (but not both.).</p> <p>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.</p> <p>Dates of Service should never span Fiscal Years. Example, June 25 – July 2 should be submitted on 2 separate claims. One claim would include June 25-June 30 and another claim would include July 1-July 2 when there are consecutive dates of service.</p> <p>Please note: Payment through Treasury is based on dates of service July 1, 2009 and forward. Payment for claims submitted with dates of service prior to July 1, 2009 should be obtained from your Administrative Entity (County).</p> <p>* Please see Appendix A (beginning on page 13 of this document) for specific billing requirements for Residential Services that are related to this block.</p>

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Block No.	Block Name	Block Code	Notes
24b	Place of Service	M	Enter the 2-digit place of service code that indicates where the service was performed. 11 – Office 12 – Home 99 – Other (Community)
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). If modifiers are applicable to the services you are billing, please enter them in the exact order they appear on your Service Authorization Notices. * For ODP Residential Providers, please see Appendix A (beginning on page 13 of this document) for specific information related to completing this block.
24e	Diagnosis Pointer	M/A	This block may contain up to four digits. If the service was provided for the primary diagnosis (in Block 21), enter 1. If provided for the secondary diagnosis, enter 2. If provided for the third diagnosis, enter 3, and for the fourth diagnosis, enter 4.

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Block No.	Block Name	Block Code	Notes
24f	\$Charges	M	<p>For Base Services, enter your county negotiated rate for the service(s) provided. For example, if your usual charge is thirty-five dollars, enter 3500.</p> <p>If billing for multiple units of service, multiply your county negotiated rate by the number of units billed and enter that amount.</p> <p>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).</p> <p>Please note: For Fiscal Year 2009-2010, the amount entered into this block may not always equal the PROMISE™ calculated allowed amount. PROMISE™ will compare the amount in the \$Charges block and the PROMISE™ calculated allowed amount and pay the lesser of the two amounts.</p>
24g	Days or Units	M	<p>Enter the number of units, services, or items provided.</p> <p>*Please see Appendix A (beginning on page 13 of this document) for specific billing requirements for Residential Services that are related to this block.</p>
24h	EPSDT/Family Planning	LB	Do not complete this block.
24i	ID Qualifier	A	<p>Enter the two-digit ID Qualifier:</p> <p>1D = 13-digit Provider ID Number (legacy #)</p>
24j (a)	Rendering Provider ID #	A	<p><i>Atypical providers</i> (non-healthcare providers) should enter the Provider ID that is attached to a Consumer's Individual Service Plan (ISP) in this block.</p> <p><i>Healthcare providers</i> (i.e. Providers who render Nursing or any of the Therapies) who are enrolled in ODP as a "group", should enter into this block the Rendering Provider's Provider ID number (nine-digit provider</p>

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Block No.	Block Name	Block Code	Notes
			number and the applicable four-digit service location – 13-digits total) of the provider who rendered the service to the individual. Note: Only one rendering provider per claim form.
24j (b)	NPI	A	Enter the 10-digit NPI number of the rendering provider. This field only applies to providers who render healthcare services (i.e Nursing or any of the Therapies). Please be sure you have registered your NPI with ODP enrollment.
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 10 alpha, numeric, or alphanumeric characters and can be used to enter the recipient's 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 identify claims if an incorrect recipient number is listed.
27	Accept Assignment?	LB	Do not complete this block.
28	Total Charge	LB	Do not complete this block.
29	Amount Paid	A	* For ODP Residential Providers, please see Appendix A (beginning on page 13) for specific information related to completing this block.
30	Balance Due	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 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).

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Block No.	Block Name	Block Code	Notes
			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.#	A/A&M/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 recipient's home or facility, enter the address of the provider's main office.
33a		A	Enter the 10-digit NPI number of the billing provider. This field only applies to providers who render healthcare services (i.e Nursing or any the Therapies)
33b		M/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #). Please ensure the Provider ID entered into this field is the same as the Provider ID that is on the Consumer's Individual Service Plan (ISP).

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**CHANGES APPLY TO FISCAL YEAR 2009-2010 SERVICE DEFINITIONS AND
FORWARD**

PURPOSE: The following information explains the unique billing rules specific to the CMS1500 for ODP provider type 52 (Residential Habilitation Providers) and provider type 51.

Block Number	Block Description	Field Requirements
24a	Dates of Service	<p>For provider types 51 and 52, do not span calendar months on claim detail lines. Please use either 2 different claim detail lines (service lines) or 2 separate claims.</p> <p>For example, for dates of service Jan 1, 2009 through Feb 3, 2009, one claim detail line (service line) should indicate Jan 1 through Jan 31 and the second claim detail line should indicate Feb 1 through Feb 3.</p> <p>From and To dates in the Dates of Service block should indicate exactly the number of days indicated in the Days or Units block (24g). For example, when From is equal to Jan 1 and To is equal to Jan 4, block 24g should equal 4.</p> <p>Ineligible Residential Codes: All Waiver Residential codes that apply to the <i>ineligible</i> portion, must be billed in the subsequent month after the service was rendered using day units. Example: Can not bill January dates of service (DOS) in the month of January. You must wait until February 1, at the earliest, before submitting the Room and Board cost and Ineligible Residential service on the claim for dates of service in January.</p>
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	<p>Many procedure codes listed in the Services and Supports Directory (HCSIS/Provider Access) have a modifier or multiple modifiers attached to them. It is imperative that the modifiers entered into block 24d are exactly in the same order as they appear on your Service Authorization Notice. Modifiers are visible on your Service Authorization Notice in either the Print or Download view.</p>

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Block Number	Block Description	Field Requirements
		<p>Modifiers UC (Medical Leave) and UD (Therapeutic Leave) are not found on your Service Authorization Notices. When billing for Medical or Therapeutic Leave, please ensure either UC or UD is entered as the <u>last</u> modifier. For example, when billing for Therapeutic Leave in a 3-Individual Home where a Registered Nurse provides Habilitation, enter procedure code W6094 TD UC where UC is the last modifier entered in block 24d.</p>
24f	\$Charges	<p>Please note: For Fiscal Year 2009-2010, the amount entered into this block may not always equal the PROMISe™ calculated reimbursed amount. PROMISe™ will compare the amount in the \$Charges block and the PROMISe™ calculated reimbursed amount and pay the lower of the two amounts.</p>
24g	Days or Units	<p>For all Residential day units (per diem), enter in this block exactly the number of days indicated in the From and To dates in the Dates of Service block (24a). For example, when From is equal to Jan 1 and To is equal to Jan 4, block 24g should equal 4 days (4 units).</p> <p>Please note: Residential services are billed in day units for Fiscal Year 2009-2010 instead of ½ month units. A provider is permitted to bill the <i>Eligible</i> Residential codes in increments of a single day, a week, or a month dates of service after the service has been rendered.</p> <p>All Waiver Residential codes that apply to the <i>ineligible</i> portion must be billed in the subsequent month after the service was rendered using day units.</p>
29	Amount Paid	<p>For provider type 52, all Residential Providers are required to enter the Consumer's contribution to room and board costs in this field. This field must be completed if you are billing an Ineligible Residential procedure code in block 24d.</p>

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Change in Consumer's Eligibility: Sometimes an individual will switch eligibility from Waiver to Base or Base to Waiver and receive services from the same provider. That provider is not permitted to bill for both Base and Waiver services on the same claim. In the above scenario, in order for the provider to receive payment for both the Base and Waiver services rendered, the provider is required to submit two separate claim transactions, one for Base services and another claim for Waiver services. If the provider does bill both Waiver and Base services on the same claim, PROMISe™ will pay the Waiver service only and the Base service will deny. In order to also receive payment for the Base service, the provider should bill for the Base service on a separate claim.

Ineligible Residential Codes: All Waiver Residential codes that apply to the *ineligible* portion, must be billed in the subsequent month after the service was rendered using day units. Example: Can not bill January dates of service (DOS) in the month of January. You must wait until February 1, at the earliest, before submitting the Room and Board cost and Ineligible Residential service on the claim for dates of service in January.

Bed Reservation Days (Therapeutic Leave and Medical Leave):

How do I Bill When I Anticipate Exceeding Federal Funding Participation (FFP) Day Limits For Bed Reservation Days?

- FFP will pay up to 30 days for Bed Reservation Days
- Bed Reservation day units are accumulated for both Medical and Therapeutic Leave individually and together.
- When either their accumulated combination is greater than 30 days, or the individual accumulated amount for medical leave or therapeutic leave is greater than 30 days, FFP ends and the State pays any excess Bed Reservation Days within the fiscal year day limitations.
- In order for payment to occur correctly, any units billed in excess of 30 day units must be billed on a separate claim detail line (service line) or separate claim.

What If I Exceed the Federal Funding Participation Day Limits For Bed Reservation Days and Don't Realize it When I Bill?

When a claim for either Therapeutic Leave or Medical Leave is billed and the date span is 31 days or more (for example: 07/01/09 – 07/31/09 = 31 units), PROMISe™ will modify the claim detail end date of service and the number of units will reflect 30 days allowed. The provider will need to bill the 31st and subsequent days on a separate claim in order to receive payment.

Billing for an Unplanned Permanent Vacancy (W7056 and W7030):

- ODP PROMISe™ Authorization is required for each unplanned Permanent Vacancy.
- ODP sends out a notice to each provider which indicates whether approval for an unplanned Permanent Vacancy has been PROMISe™ authorized.

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- If approval has been PROMISE™ authorized for an unplanned Permanent Vacancy, the ODP notice sent to you will contain an authorization number that you are required to enter on your claim submission in order to receive payment.
- Services that have been issued a PROMISE™ authorization number can only be billed on one single claim. Only the unplanned Permanent Vacancy codes for the ineligible and eligible components are permitted on one single claim. No other service detail lines unrelated to the authorized service(s) are permitted on the claim with the PROMISE™ authorized services.
- Provider must enter in Block 1a of the CMS1500 the Recipient Identification Number (RID) of the individual who caused the unplanned Permanent Vacancy in order to receive payment for the Eligible and Ineligible portion of the Unplanned Permanent Vacancy.

What if I want to render respite services during an Unplanned Permanent Vacancy?

- If during an unplanned Permanent Vacancy a residential provider decides to temporarily use the unplanned Permanent Vacancy for respite, then the provider must contact their Regional Office.
- The ODP Regional Office will end date the authorization for the unplanned Permanent Vacancy with an end date that is equal to the first day respite is rendered.
- The days for the unplanned Permanent Vacancy will stop accumulating the first day that the respite service is provided during the unplanned Permanent Vacancy.
- At the completion of the respite service, the unplanned permanent vacancy will be re-authorized and the units will begin accumulating again from the point that the unplanned Permanent Vacancy was end dated for the respite service.
- When respite is billed in this situation, the unplanned Permanent Vacancy can not be billed. If an unplanned Permanent Vacancy is billed during the same dates of service as the respite, an edit will post and the claim detail line for the unplanned Permanent Vacancy will deny.