

CMS-1500 Billing Guide Adult Autism 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:

Adult Autism 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.
 - 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.

Special Notes **Adult Autism Waiver is for ages 21 and older**

PROMIS^e™ 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.

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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 your established rate without a decimal point. You must include the dollars and cents. If the rate is thirty-five dollars, enter:

24F	
\$CHARGES	
35	00

Example #2: When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay 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 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. 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 beneficiary number found on the beneficiary's 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 provide the 10-digit beneficiary number to use for this block.
2	Patient's Name	O	Enter the beneficiary'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 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	A	If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word SAME . If the patient has MA coverage only, leave the block blank.
9a	Other Insured's Policy or Group Number	A	This block identifies a secondary insurance other than MA, and the primary insurance listed in 11a–d. Enter the policy number <u>and</u> the group number of any secondary insurance that is available. Only use Blocks 9, 9a and 9d, if you have completed Blocks 11a, 11c and 11d, and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.)
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	A	Enter the other insured's insurance plan name or program name.
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	A/A	Enter the policy number and group number of the primary insurance other than MA.
11a	Insured's Date of Birth and Sex	A/A	

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Block No.	Block Name	Block Code	Notes
11b	Other Claim ID (Designated by NUCC)	LB	Do not complete this block.
11c	Insurance Plan Name or Program Name	A	List the name and address of the primary insurance listed in Block 11.
11d	Is There Another Health Benefit Plan?	A	If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the YES box is checked, Blocks 9, 9a and 9d must be completed with the information on the additional resource.
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 eight-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes.)
13	Insured's or Authorized Person's Signature	LB	Do not complete this block.
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.

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Block No.	Block Name	Block Code	Notes
17a	I.D. Number of Referring Provider	LB	Do not complete this block.
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	<p>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., AT05).</p> <p>Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,).</p> <p>DPW does not require that you attach insurance statements to the claim (<u>with the exception of Medicare claims</u>). (<u>If the beneficiary has Medicare and MA, see *note below.</u>) However, the number and type of statements on file is required, and the codes in this block provide that information.</p> <p>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.</p> <p>For a complete listing and description of Attachment Type Codes, please refer to the CMS-1500 Claim Form Desk Reference, located in Appendix A of the handbook.</p> <p><i>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.</i></p> <p>Qualified Small Businesses</p>

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Block No.	Block Name	Block Code	Notes
			<p>Qualified small businesses must <u>always</u> enter the following message in Block 19 (Additional Claim Information (Designated by NUCC)) of the CMS-1500, in addition to any applicable attachment type codes:</p> <p>“(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.”</p> <p>*Note: If the beneficiary has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter AT05 in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim. Please refer to MA 539 for additional information.</p>
20	Outside Lab?	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	<p>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.</p> <p>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 diagnosis.</p> <p>The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable.</p>
22	Resubmission Code	A/A	<p>This block has two uses:</p> <ol style="list-style-type: none"> 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

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			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).
23	Prior Authorization Number	LB	Do not complete this block.
24a	Date(s) of Service	M/M	Enter the applicable date of service using an eight-digit (MMDDCCYY) format to record the From or To dates, (e.g. 03012007). Complete either the From or the To column (but not both). Do not bill for consecutive dates, each service must be billed on a separate claim line.
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 portion of this block, enter the pricing modifier first if required to pay the claim. Use the third portion of this block to indicate up to three additional informational modifiers, when applicable. If no pricing modifier is required, enter up to four additional / informational modifier(s) using the second and third

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Block No.	Block Name	Block Code	Notes
			portions of this block. Failure to use the appropriate modifier(s) will result in inappropriate claims payment or denial.
24e	Diagnosis Pointer	M/A	<p>This block may contain up to four letters.</p> <p>Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21.</p> <p>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.</p> <p>Note: The primary diagnosis pointer must be entered first.</p>
24f	\$Charges	M	<p>Enter the established rate from the fee schedule for the service(s) provided. For example, if your established rate is thirty-five dollars, enter 3500.</p> <p>If billing for multiple units of service, multiply the established rate from the fee schedule by the number of units billed and enter that amount.</p>
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	<p>Enter the two-digit ID Qualifier:</p> <p>G2 = 13-digit Provider ID Number (legacy #)</p>
24j (a)	Rendering Provider ID #	A	<p>Complete with the Rendering Provider's Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total).</p> <p>Note: Only one rendering provider per claim form.</p>
24j (b)	NPI	A	Enter the 10-digit NPI number of the rendering provider.

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Block No.	Block Name	Block Code	Notes
25	Federal Tax I.D. Number	A	Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an X in the appropriate block. For Intermediate Service Organization (ISO) claims, enter the SSN of the direct care provider (subcontractor).
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 beneficiary'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 beneficiary 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	If a beneficiary is to pay a portion of their medical bills as determined by the local County Assistance Office (CAO), enter the amount to be paid by the beneficiary. Patient pay is only applicable if notification is received from the local CAO on a PA 162RM form. Do not enter copy in 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 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).

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Block No.	Block Name	Block Code	Notes
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 beneficiary'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/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #)