

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



FACT SHEET

Medicare Billing: 837P and Form CMS-1500

What are the 837P and Form CMS-1500?

837P: The 837P (Professional) is the standard format used by health care professionals and suppliers to transmit health care claims electronically. Review the chart below "ANSI ASC X12N 837P" for more information about this claim format.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Form CMS-1500: The Form CMS-1500 is the standard paper claim form that health care professionals and suppliers use to bill Medicare Administrative Contractors (MACs) when a paper claim is allowed. In order to align the CMS-1500 with some of the changes in the electronic format, the previous 08/05 version was revised to the 02/12 version. Visit the [National Uniform Claim Committee \(NUCC\) website](#) for information on the revision process. CMS designates the 1500 Health Insurance Claim Form as the CMS-1500 (02/12) and the form is referred to throughout this fact sheet as the CMS-1500.

In addition to billing Medicare, the 837P and Form CMS-1500 may be suitable for billing various government and some private insurers. Data elements in the Centers for Medicare & Medicaid Services (CMS) uniform electronic billing specifications are consistent with the hard copy data set to the extent that one processing system can handle both.

ANSI ASC X12N 837P

The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P (Professional) Version 5010A1 is the current electronic claim version. To learn more, visit the [ASC X12 website](#) on the Internet.

ANSI = American National Standards Institute

ASC = Accredited Standards Committee

X12N = Insurance section of ASC X12 for the health insurance industry's administrative transactions

837 = Standard format for transmitting health care claims electronically

P = Professional version of the 837 electronic format

Version 5010A1 = Current version of the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards for health care professionals and suppliers.

The NUCC has developed a [crosswalk](#) between the ASC X12N 837P and the hard copy claim form located on the Internet. MACs may also include a crosswalk on their websites.

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Implementation and Companion Guides for Electronic Transactions

Health care professionals or suppliers billing electronic claims must comply with the ASC X12N implementation guide. The [“837P Health Care Claim: Professional”](#) implementation guide is available for purchase and provides instructions on the content and format requirements for each of the standards’ requirements. ASC X12N implementation guides are the specific technical instructions for implementing each of the adopted HIPAA standards and provide instructions on the content and format requirements for each of the standards’ requirements. These documents are written for use by all health benefit payers, not specifically for Medicare. Implementation Guides, including Version 5010 Consolidated Guides, can also be purchased from the [Washington Publishing Company](#) on the Internet.

CMS publishes a companion guide to supplement the implementation guide and provide further instruction specific to Medicare. The [“5010A1 Part B 837 Companion Guide”](#) is located on the CMS website and provides specific 837P claim loop and segment references. MACs also publish their own companion documents, which provide additional information specific to that contractor’s business. To locate a MAC’s companion guide, visit that contractor’s website.

Please note that the implementation guides and companion guides are technical documents and health care professionals or suppliers may require assistance from software vendors or clearinghouses to interpret and implement the information within the guides.

Medicare Claims Submissions

The “Medicare Claims Processing Manual” (Internet-Only Manual Publication [IOM Pub.] 100-04) is found on the [IOM](#) web page. This publication includes instructions on claims submission. [Chapter 1](#) includes general billing requirements for various health care professionals and suppliers. Other chapters offer claims submission information specific to a health care professional or supplier type. Once in IOM Pub. 100-04, look for a chapter(s) applicable to your health care professional or supplier type and then search within the chapter for claims submission guidelines. For example, [Chapter 20](#) is entitled “Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).”

Visit [Chapter 24](#) to learn more about electronic filing requirements, including the Electronic Data Interchange (EDI) enrollment form that must be completed prior to submitting Electronic Media Claims (EMCs) or other EDI transactions to Medicare. Refer to [Chapter 26](#) to learn what should be included in the 837P or in each item of the CMS-1500. The [“Medicare Benefit Policy Manual”](#) (IOM Pub. 100-02) and the [“Medicare National Coverage Determinations \(NCD\) Manual,”](#) (IOM Pub. 100-03) both include coverage information that may be helpful in claims submission. Search for coverage guidance once within a chapter.

Coding

Correct coding is key to submitting valid claims. To ensure claims are as accurate as possible, use current valid diagnosis and procedure codes and code them to the highest level of specificity (maximum number of digits) available. [Chapter 23](#) of the “Medicare Claims Processing Manual” is entitled “Fee Schedule Administration and Coding Requirements” and includes information on diagnosis coding and procedure coding, as well as instructions for codes with modifiers.

Diagnosis Coding

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), is currently used to code diagnostic information on claims. The United States Government no longer publishes the ICD-9-CM. Multiple entities publish ICD-9-CM manuals and the full ICD-9-CM is available for purchase from the [AMA Bookstore](#) on the Internet.

ICD-10-CM (10th revision) will replace the ICD-9-CM to report diagnoses at a future date. More information about the transition is available on the [ICD-10](#) web page, which explains the recommended steps to plan and prepare for this new system.

Procedure Coding

Use Healthcare Common Procedure Coding System (HCPCS) Level I and II codes to code procedures on all claims. Level I Current Procedural Terminology (CPT-4) codes describe medical procedures and professional services. CPT is a numeric coding system maintained by the AMA. The “CPT” code book is available from the [AMA Bookstore](#) on the Internet.

The Medicare Learning Network® (MLN) offers a downloadable guide about Evaluation and Management (E/M) codes which are a subset of HCPCS Level I codes. The “[Evaluation and Management Services Guide](#)” is available on the CMS website.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and DMEPOS when used outside a physician’s office or injections administered within a physician’s office or clinic. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the Level II HCPCS codes, or alpha-numeric codes as they may be referred to, were established for submitting claims for these items. These codes are found in the “Health Care Procedure Coding System (HCPCS)” code book or by visiting the [Alpha-Numeric HCPCS](#) web page.

Modifiers

Proper use of modifiers with procedure codes is essential to submitting correct claims. The AMA’s “CPT” code book includes HCPCS Level II codes and modifiers, while the “HCPCS” code book includes HCPCS Level II codes and related modifiers. Resources about modifiers on the CMS website include:

- The “[Modifier 59](#)” article explains the correct use of -59 as a distinct procedural service;
- The [Physician Quality Reporting System \(PQRS\)](#) web page explains the incentive payment to practices with eligible professionals who satisfactorily report data on their claims;
- The [Physician Bonuses](#) web page outlines whether or not a modifier is required to receive the Health Professional Shortage Area (HPSA) bonus payment; and
- Chapters of the “Medicare Claims Processing Manual” (IOM Pub. 100-04) also offer modifier information. For example, [Chapter 30](#) includes information related to modifiers for Advance Beneficiary Notices (ABNs).

Submitting Accurate Claims

Health care professionals and suppliers play a vital role in protecting the integrity of the Medicare Program by submitting accurate claims, maintaining current knowledge of Medicare billing policies, and ensuring all documentation required to support the medical need for the service rendered is submitted when requested by the MAC.

In addition to correct claims completion, Medicare payment requires that an item or service:

- Meets a benefit category;
- Is not specifically excluded from coverage; and
- Is reasonable and necessary.

In general **fraud** is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist.

Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program.

It is a crime to defraud the Federal government and its programs. Punishment may involve imprisonment, significant fines, or both under a number of laws including the False Claims Act, the Anti-Kickback Statute, the Physician Self-Referral Law (Stark Law), and the Criminal Health Care Fraud Statute.

For more information about Medicare Program integrity functions and how health care professionals and suppliers can help to protect Medicare from fraud and abuse, reference the “Medicare Program Integrity Manual” (IOM Pub. 100-08, [Chapter 4](#)) on the CMS website. The MLN also provides a fact sheet titled “[Medicare Fraud & Abuse: Prevention, Detection, and Reporting](#).” This fact sheet is designed to provide education on preventing, detecting, and

reporting Medicare fraud and abuse. It includes definitions as well as information on laws, partnerships with other organizations, and resources for additional information.

The MLN also provides a number of [compliance education products](#) designed to help health care professionals and suppliers submit accurate claims.

When Does Medicare Accept a Paper Form CMS-1500?

Initial claims for payment under Medicare must be submitted electronically unless a health care professional or supplier qualifies for a waiver or exception from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims.



ASCA Exceptions: Before submitting a hard copy claim on the Form CMS-1500, health care professionals and suppliers should self-assess to determine if they meet one or more of the ASCA exceptions. For example, health care professionals and suppliers that have fewer than 10 Full-Time Equivalent (FTE) employees and bill a MAC are considered to be small and might therefore qualify to be exempt from Medicare electronic billing requirements. If a health care professional or supplier meets an exception, there is no need to submit a waiver request.

Waiver Requests: There are other situations when the ASCA electronic billing requirement could be waived for some or all claims, such as if disability of all members of a health care professional's or supplier's staff prevents use of a computer for electronic submission of claims. Health care professionals and suppliers must obtain Medicare pre-approval to submit paper claims in these situations by submitting a waiver request to their MAC.

Refer to [Chapter 24](#), Sections 90-90.6, of the "Medicare Claims Processing Manual" (IOM Pub. 100-04) for further information on ASCA electronic billing requirements and enforcement reviews of health care professionals and suppliers.

Download a sample of the Form CMS-1500 by visiting the [CMS Forms List](#) web page. In the Filter On box, enter 1500. Copies of the CMS-1500 should not be downloaded for submission of claims, since they may not accurately replicate colors included in the form. These colors are needed to enable automated reading of information on the form. Visit the [U.S. Government Bookstore](#) to order the form. The CMS-1500 is also available from printing companies and office supply stores, as long as it follows the CMS approved specifications found in the "Medicare Claims Processing Manual" (IOM Pub. 100-04, [Chapter 26](#), Section 30).

Timely Filing

Medicare claims must be filed to the appropriate MAC no later than 12 months, or one calendar year, after the date of service.

Medicare will deny claims if they arrive after the deadline date. When a claim is denied for having been filed after the timely filing period, such a denial does not constitute an initial determination. As such, the determination that a claim was not filed timely is not subject to appeal.

Medicare uses the line item 'From' date to determine the date of service for claims filing timeliness for claims submitted by health care professionals and suppliers that include span dates of service. (This includes Durable Medical Equipment (DME) supplies and rental items.) If a line item 'From' date is not timely but the 'To' date is timely, contractors must split the line item and deny the untimely services as not timely filed.

Medicare regulations allow exceptions to the 12-month time limit for filing claims. To review these exceptions, refer to the "Medicare Claims Processing Manual" (IOM Pub. 100-04, [Chapter 1](#)) on the CMS website.

Where to Submit FFS Claims

For beneficiaries enrolled in Original (Fee-For-Service) Medicare, health care professionals or suppliers submit claims for services to the appropriate MAC. Contact the MAC by referencing the "[Review Contractor Directory - Interactive Map](#)" on the CMS website. Medicare beneficiaries cannot be charged for completing or filing a claim. Health care professionals and suppliers may be subject to penalty for violations.

For beneficiaries enrolled in a Medicare Advantage (MA) Plan, health care professionals or suppliers should submit claims to the beneficiary's MA Plan. CMS provides a list of [MA claims processing contacts](#) on the CMS website.

Medicare Secondary Payer (MSP)

MSP provisions apply to situations when Medicare is not the beneficiary's primary health insurance coverage and ensure that Medicare does not pay for services and items that certain other health insurance or coverage is primarily responsible for paying. For more information, reference the "[Medicare Secondary Payer for Provider, Physician, and Other Supplier Billing Staff](#)" fact sheet available through the "MLN Catalog" on the CMS website. The [Medicare Secondary Payer](#) web page offers information on MSP laws and the various methods employed by CMS to gather data on other insurance that may be primary to Medicare.

Where to Learn More

WEB PAGES

Electronic Billing & EDI Transactions

<http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/index.html>

To read more about submission of electronic claims, visit the CMS Electronic Billing & EDI Transactions web page.

Health Care Payment and Remittance Advice

<http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/Remittance.html>

MACs use a notice called a Remittance Advice (RA) as a means to communicate to health care professionals and suppliers claim processing decisions such as payments, adjustments, and denials. The Health Care Payment and Remittance Advice web page offers information on the 835 standard transaction for the Electronic Remit Advice (ERA) and the Standard Paper Remit (SPR).

HIPAA Versions 5010 and D.0 & 3.0

<http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/Versions5010andD0/index.html>

This section of the CMS website contains information and educational resources pertaining to Version 5010, which is the version of the X12 standards for HIPAA transactions.

MLN Guided Pathways (GP) to Medicare Resources

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/GuidedPathways.html>

The MLN Guided Pathways (GP) to Medicare Resources web page helps health care professionals, providers, suppliers, and contractors gain knowledge on resources and products related to Medicare and the CMS website.

National Correct Coding Initiative Edits

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

In the left column of this web page are NCCI edits for physician and hospital outpatient claims and Medically Unlikely Edits (MUEs).

Professional Paper Claim Form (CMS-1500)

http://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/16_1500.html

This web page contains information about submitting paper claims. Click on Administrative Simplification Compliance Act Self Assessment in the left column to read about the limited circumstances when an initial claim may be a paper claim.

WEB-BASED TRAINING (WBT) COURSES

"Medicare Billing: 837P and Form CMS-1500"

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html>

This web-based training course is designed to provide education on how to accurately file Medicare Part B claims. It includes information and directions for billing that will help to reduce or eliminate the chances of receiving

unprocessable rejections. To locate this course, scroll down the page and select Web-Based Training (WBT) Courses.

“HIPAA EDI Standards”

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html>

This web-based training course is designed to provide education on electronic billing, transaction standards, and code sets. It includes an overview of the steps involved in the Medicare electronic data interchange process. To locate this course, scroll down the page and select Web-Based Training (WBT) Courses.

“Medicare Billing Certificate Program for Part B Providers”

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html>

This program is designed to provide education on Part B of the Medicare Program. It includes required web-based training courses, readings, and a list of helpful resources. Upon successful completion of this program, you will receive a certificate in Medicare billing for Part B providers from CMS. To locate this course, scroll down the page and select Web-Based Training (WBT) Courses.

“Medicare Secondary Payer Provisions”

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html>

This web-based training course is designed to provide education on the MSP provisions. Understanding and correctly applying these provisions when submitting claims to Medicare can reduce claim submission errors. To locate this course, scroll down the page and select Web-Based Training (WBT) Courses.

INTERNET-ONLY MANUAL

“Medicare Claims Processing Manual,” IOM Pub. 100-04, Chapter 26, “Completing and Processing the Form CMS-1500 Data Set”

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf>

Chapter 26 outlines billing requirements for health care professionals and suppliers using the 837P or Form CMS-1500.

GUIDES

“Evaluation and Management Services Guide”

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

This guide is designed to provide education on evaluation and management services. It includes the following information: medical record documentation, evaluation and management billing and coding considerations, and the “1995 Documentation Guidelines for Evaluation and Management Services” and the “1997 Documentation Guidelines for Evaluation and Management Services.”

“MLN Guided Pathways: Basic Medicare Resources for Health Care Professionals, Suppliers, and Providers”

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf

This basic curriculum includes information about Medicare resources applicable to all health care professionals, suppliers, and providers.

“MLN Guided Pathways: Intermediate Medicare Resources for Health Care Professionals and Suppliers (855B)”

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Intermediate_PartB_Booklet.pdf

This intermediate curriculum provides detailed resources for information on Medicare policies and requirements applicable to physicians, non-physician practitioners, and suppliers who enroll using the CMS-855B, CMS-855I, CMS-855O, or CMS-855S enrollment applications.

“MLN Guided Pathways: Provider Specific Medicare Resources”

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf

This advanced curriculum includes specialty and facility specific information for Medicare institutional providers, physicians, health care professionals, and suppliers.

BOOKLETS

“How to Use the National Correct Coding Initiative (NCCI) Tools”

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How-To-Use-NCCI-Tools.pdf>

This booklet is designed to provide education on how to navigate the CMS NCCI web pages. It includes information on how to look up Medicare code pair edits and MUEs, as well as an explanation of how the NCCI tools can help providers avoid coding and billing errors and subsequent payment denials.

“Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and Recovery Audit Program”

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MCRP_Booklet.pdf

This booklet is designed to provide education on the different CMS claim review programs and assist providers in reducing payment errors; in particular, coverage and coding errors. It includes frequently asked questions, resources, and an overview of the various programs, including Medical Review, Recovery Audit Program, and the Comprehensive Error Rate Testing (CERT) Program.

“The National Provider Identifier (NPI): What You Need to Know”

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPIBooklet.pdf>

This booklet is designed to provide education on the NPI. It includes information on NPI basics, the National Plan and Provider Enumeration System (NPPES), health care provider categories, and how to apply for an NPI.

“Medicare Enrollment and Claim Submission Guidelines”

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedicareClaimSubmissionGuidelines-ICN906764.pdf>

This booklet is designed to provide education on applying for enrollment and submitting claims to Medicare. It includes the following information: enrolling in the Medicare Program; private contracts with Medicare beneficiaries; Medicare claims; deductibles, coinsurance, and copayments; Beneficiary Notices of Noncoverage; and billing requirements.

OTHER MLN PRODUCTS

“Medicare Learning Network® (MLN) Suite of Products & Resources for Billers and Coders”

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Billers_and_Coders_Suite_of_Products_Listings.pdf

This educational web guide is designed to provide education on Medicare Program policies and procedures, accurate claims review and submission, business requirements and federal initiatives and incentives. It includes information and direct links to billing and coding products designed to equip office professionals with a better understanding of the Medicare Program basics and accurate billing procedures.

New Maximum Period for the Submission of Medicare Claims Podcast

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Multimedia.html>

This podcast is designed to provide education on the new maximum period that health care professionals and suppliers have for the submission of Medicare claims. It includes information to determine the date of service on the claim statement. In the Filter On box, enter the name of the podcast.



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