MSA
MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin Number: MSA 07-09

Distribution: Practitioners (Physicians, Advanced Practice Nurses, Physical Therapists, Medical Clinics, FQHC/RHCs/THCs, Oral Surgeons, Podiatrists, CRNA), Chiropractors, Ambulance, Independent Labs, Medical Suppliers, Orthotists/Prosthetists, Vision, Hearing Centers, Hearing Aid Dealers, Community Mental Health Services Programs, Prepaid Inpatient Health Plans, Family Planning Clinics, Maternal Infant Health Program, Private Duty Nurses (Individually Enrolled),School Based Services, Medicaid Health Plans and Local Health Departments

Issued: February 1, 2007

Subject: Implementation of the CMS 1500 (Version 08/05), New Claim Completion Instructions (Including NPI), Guidelines for Submitting Paper Test Claims, and Revisions to Billing and Reimbursement for Professionals Chapter

Effective: April 1, 2007

Programs Affected: Medicaid, Children's Special Health Care Services (CSHCS), Adult Benefits Waiver (ABW), Maternity Outpatient Medical Services (MOMS), Serious Emotional Disturbance (SED), Children's Waiver Program (CWP), Plan First

Implementation of the CMS 1500 (Version 08/05)

Effective on April 1, 2007, the Michigan Department of Community Health (MDCH) will be converting to the CMS 1500 (08/05) paper claim form. Any former CMS 1500 (12/90) claim forms submitted on or after this date will not be accepted. The revised format accommodates the reporting of the National Provider Identifier (NPI) and other supplemental information.

The final CMS 1500 (08/05) claim form, with the CMS OMB number in the bottom right-hand corner, is posted on the National Uniform Claim Committee (NUCC) website at www.nucc.org. Please refer to this website for more information on purchasing the new claim forms.

CMS 1500 (08/05) New Claim Completion Instructions

The NUCC standard completion instructions for the CMS 1500 (08/05) claim form must be followed for claims submitted to MDCH. However, the mandatory completion of specific provider fields will change after the NPI transition period ends on May 23, 2007.

Prior to May 23, 2007, the Medicaid legacy provider ID numbers are required in all applicable provider fields on the paper claim form for claim adjudication. To assist MDCH with testing claims for the NPI crosswalk, both the Medicaid legacy provider ID number and the NPI must be reported.

On and after May 23, 2007, the NPI is required in all applicable provider fields. The Medicaid legacy provider ID number is not needed.

The following fields represent the new completion instructions for MDCH:

Field 17a./17b. – Name of Referring, Ordering, or Supervising Provider:

17. – Enter the name (First name, Middle Initial, Last Name) and credentials of the professional who referred, ordered or supervised the service(s) or supply(s) on the claim. If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider 2. Ordering Provider 3. Supervising Provider

17a. – Enter the two-digit Medicaid qualifier (1D) in the shaded area to the immediate right of 17a. For the shared area within 17a., enter the nine-digit Medicaid legacy provider ID number (two-digit provider type and seven-digit provider ID number). If the referring, ordering, or supervising provider is not enrolled in Medicaid, enter nine 8's (888888888).
17b. – Enter the 10-digit NPI number of the referring provider, ordering or supervising provider.

Refer to the Medicaid Provider Manual for situations where the referring provider ID number is required for MDCH. The referring/ordering provider ID number is always required when billing the following services:

- Laboratory
- Consultation Services
- Non-emergency Ambulance Services

If the referring/ordering/supervising provider identifier is required, the NPI must be reported on and after May 23, 2007 and the legacy provider number is not needed.

Field 24A – 24D – Supplemental Information

To assist MDCH in obtaining drug rebate information, report the following national drug code (NDC) supplemental information in the shaded lines of Field 24 for all physician administered drugs:

- N4 – (2-digit qualifier)
- National Drug Code (NDC) – (11-digit code with 5-4-2 format)
- Description of Drug
- NDC Unit/Basis for Measurement Qualifier – (2-digit qualifier)
- NDC Quantity

The following qualifiers are to be used when reporting NDC Unit/Basis for Measurement

F2 – International Unit	ML – Milliliter
GR – Gram	UN – Unit

To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code. Enter three blank spaces between the next qualifier and number/code/information. In the example below, three spaces must be entered between the description of the drug and the NDC unit qualifier.

Example: The NDC information may be reported as follows:

N400026064871 Immune Globulin Intravenous   UN2

Field 24C – EMG – Emergency – Enter the appropriate emergency code:

Y = emergency
N = not an emergency

Field 24I./24J. – Rendering Provider – Enter the two-digit Medicaid qualifier (1D) in the shaded area of 24I. Report the nine-digit Medicaid legacy provider ID number in the shaded area of 24J. For the non-shaded area of 24J, report the 10-digit NPI number of the individual performing or rendering the service.

The rendering provider identifier is required if different from the provider billing the service. **If the rendering provider identifier is required, the NPI must be reported on and after May 23, 2007** and the legacy provider number is not needed.

Field 32a./32b. – Service Facility Location Information:

32a. – Enter the 10-digit NPI number of the service facility location in 32a.
32b. – Enter the two-digit Medicaid qualifier (1D) along with the nine-digit Medicaid legacy provider ID number.

The service facility location information is required if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or the physician's office. Also, complete this item if place of service code "99" is used. **If the service facility location identifier is required, the NPI must be reported on and after May 23, 2007** and the legacy provider number is not needed.

Field 33a./33b. – Billing Provider Information and Phone Number:

33a. – Enter the 10-digit NPI number of the billing provider.
33b. – Enter the two-digit Medicaid qualifier (1D) followed by the 9-digit Medicaid legacy provider ID number.

The billing provider identifier is required on all CMS 1500 claim forms. The NPI must be reported on and after May 23, 2007 and the legacy provider number is not needed.

Coordination of Benefits (COB) Information – Due to the elimination of the COB fields from the CMS 1500 (08/05), a paper copy of the Explanation of Benefits must be included for all claims reporting other payer information. To prevent delays in payment, MDCH is recommending electronic submission utilizing the 837 professional 4010A1 claim format which accommodates the other payer information.

Guidelines for Submitting Paper Test Claims

To ensure proper scanning and adjudication by MDCH, providers are encouraged to submit paper test claims to the Computer Operations staff. CMS 1500 (08/05) test claims must be on a form printed with red ink with the Approved OMB number of 0938-0999 in the lower right corner. Use of forms other than the red ink version will result in errors when they are scanned by the Optical Character Reader (OCR). Refer to the Billing and Reimbursement for Professionals Chapter of the Medicaid Provider Manual for complete instructions on preparation of a paper claim form.

A minimum of 10 test claims should be submitted to:

Medicaid Payment Division
Attn: Test Claims
320 South Walnut Street
Lansing, Michigan 48913

Note: Test claims are not processed for payment but are used only to verify correct processing of a provider's claim forms.

Revision to Billing and Reimbursement for Professionals Chapter

The Billing and Reimbursement for Professionals Chapter of the Medicaid Provider Manual will be revised during the April Quarterly 2007 Update. The complete instructions for each claim field will be removed as the NUCC standard completion instructions must be followed for claims submitted to MDCH. Only additional instructions unique for MDCH claim adjudication will be published to providers.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA | PICA

CARRIER

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | TRICARE CHAMPUS (Sponsor's SSN) | CHAMPVA (Member ID#) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS — Single Married Other; Employed, Full-Time Student, Part-Time Student

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___ 3. ___ . ___

2. ___ . ___ 4. ___ . ___

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

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

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

(PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.