

Follow CMS-1500 Claim Form Guidelines (02/12 Version) to Avoid Claims Rejections

In January 2014, BlueCross implemented the CMS-1500 Claim Form (02/12 Version). Due to changes on this new version of the claim form, BlueCross has experienced a high volume of rejections. Please see the information listed below for each form locator in order to help prevent rejections.

Details concerning all boxes for this form can be found in the NUCC CMS1500 Claim Form Manual at the following link.

http://nucc.org/images/stories/PDF/1500_claim_form_instruction_manual_2012_02-v4.pdf

These requirements align with the requirements in the Accredited Standards Committee X12 (ASC X12) Health Care Claim: Professional (837P) Version 5010 Technical Report Type 3 (5010) and 005010X222A1 Technical Report Type 3 (5010A1).

The BlueCare Tennessee and Commercial Provider Administration Manuals will be updated as needed to reflect the information in this document.

Boxes 1a Insured's ID Number & 11 Insured's Policy Group or FECA Number

Paper claims are being rejected with edit **500401 SUBSCRIBER NAME OR ID**. The primary reason this reject is happening is because claims are being submitted with the same information in Boxes 1a Insured's ID Number and 11 Insured's Policy Group or FECA Number. Most of the errors reviewed have been because the provider is submitting the Subscriber ID in both blocks. The provider should check the member's ID card for both pieces of information and file them correctly.

Box 1a

1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
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Box 11

11. INSURED'S POLICY GROUP OR FECA NUMBER

Box 10d Claim Codes

10d. CLAIM CODES (Designated by NUCC)

The guidelines for Box 10d on the CMS1500 Claim Form have changed. This box was previously reserved for local use but should now be used to enter Claim Codes that identify additional information about the claim or patient's condition.

- The Condition Codes approved for use on the 1500 Claim Form are available at <http://www.nucc.org/> under Code Sets.
- For Worker's Compensation Claims – Condition Codes are required when submitting a bill that is a duplicate or an appeal. The Original Reference Number must be entered in the Original Ref. No. area of Box 22 for these situations. Do not use Condition Codes when submitting a revised or corrected bill.
- This field will allow for the entry of 19 characters.
- When reporting more than one code, enter three blank spaces and then the next code.

If this box is not completed according to these instructions the claim will be rejected back to the provider.

Box 14 - Date of Current Illness, Injury, or Pregnancy (LMP)

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)			
MM	DD	YY	QUAL.

This box is used to report the onset of acute symptoms for a current illness or condition or that the services are related to the patient's pregnancy. There are two valid qualifiers for this box, these qualifiers and their guidelines are listed below.

- 431 (Onset of Current Symptoms or Illness) – This information is required for the initial medical service or visit performed in response to a medical emergency when the date is available and is different than the date of service. The date entered in this box should not be the same as the date of service, if the dates entered are the same the claim will be returned unprocessed.
- 484 (Last Menstrual Period) – This information is required when, in the judgment of the provider, the services on this claim are related to the patient's pregnancy.

Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.

Enter the applicable qualifier to identify which date is being reported. Enter the qualifier to the right of the vertical, dotted line.

Box 15 Other Date & Qualifiers 444 First Visit or Consultation & 454 Initial Treatment

This is to clarify when it is appropriate to use Qualifier '444' in Box 15 on the CMS1500 claim. Qualifier '444' should only be used to report the date of first contact for Property & Casualty claims. This qualifier also requires the submission of a Property & Casualty claim number in box 11b along with a 'Y4' qualifier. If these two pieces of information are not reported correctly the claim will be rejected back to the provider unprocessed.

To submit the date of initial treatment for spinal manipulation, physical therapy, occupational therapy, speech language pathology, dialysis, optical refractions, pregnancy, etc. Qualifier '454' Initial Treatment should be used.

Box 15

444 First Visit or Consultation
454 Initial Treatment

15. OTHER DATE			
QUAL	MM	DD	YY

Box 11b

Y4 Agency Claim Number (Property Casualty Claim Number)

b. OTHER CLAIM ID (Designated by NUCC)
Y4 112233445566

Box 17 Name of Referring Provider or Other Source

Paper claims are being rejected with edit **500404 MISSING OR BAD QUALIFIER BOX 17**. This error is caused when the qualifier for Box 17 Name of Referring Provider or Other Source is invalid or left blank but the provider's information, NPI, UPIN, etc. is submitted in Boxes 17a and or 17b. The valid qualifiers for Box 17 are listed below and should be submitted to the left of the vertical, dotted line in this box.

DN Referring Provider
DK Ordering Provider
DQ Supervising Provider

Box 17

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
DN Jane A Smith MD

Boxes 21 Diagnosis or Nature of Illness or Injury

Paper claims are being rejected with edit **502428 LNITM DIAG CD POINTER ERR OR DUPE**. The Diagnosis Codes entered in Box 21 are now referenced as by alpha (A – L) pointers rather than numeric pointers. The Diagnosis Pointers listed in box 24E should also be reported using the alpha character that relates to the reason the service(s) was performed. Numeric entries in box 24E are not valid and will be rejected with this edit.

Box 21

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)			ICD Ind.	9			
A.	99859	B.	7806	C.	V180	D.	E8788
E.		F.		G.		H.	
I.		J.		K.		L.	

Box 24E

E. DIAGNOSIS POINTER
ABCD

Patient Account Number - CMS1500 (Box 26) & UB04 Claims (FL 03a)

NUCC and NUBC guidelines require the submission of the Patient's unique (alphanumeric) number assigned by the provider to facilitate retrieval of the individual's account of services (accounts receivable) containing the financial billing records and any postings of payment. This information should be submitted as follows:

- CMS1500 – Box 26 **Patient's Account No.** (up to 14 alphanumeric characters)
- UB04 – Form Locator 03a **Patient Control Number** (up to 20 alphanumeric characters)
- For all electronic claims the **Patient Control Number** should be submitted in the 2300 Claim Information Loop CLM01 SEGMENT (20 alphanumeric characters)
- This is a required field and at least one character must be submitted.
- For claims filed in an 837 ASC X12 format the MAXIMUM NUMBER OF CHARACTERS to be supported for this field is '20'. Providers may submit fewer characters depending upon their needs. However, the HIPAA maximum requirement to be supported by any responding system is '20'. Characters beyond 20 are not required to be stored nor returned by any 837-receiving system.

Claims submitted without this information on or after April 1, 2015 will be rejected back to the provider unprocessed.