APPENDIX E: Tips for Completing the CMS (HCFA) 1500 Claim

Field Number	Field Description	Data Type	Instructions
Client / Member Information (Fields 1-13)			
1	Coverage	Not required	Check the appropriate box with an "X".
1a	Insured's ID number	Required	Enter the client's EMS ID number.
2	Patient's Name	Required	Enter the client's full name – last name first, first name second, middle initial last.
3	Patient's birth date and gender	Required	Enter the client's birth date, and check the box that corresponds to the client's gender.
4	Insured's name	Conditional	If patient is not the insured, enter the insured's name (last name, first name, middle initial).
5	Patient's address, city, state, zip code and telephone number	Required	Enter the client's address (apartment/PO box number, street, city, state, zip code).
6	Patient's relationship to the insured	Required	Place and "X" in the box indicating the patient's relationship to the insured.
7	Insured's address, city, state, zip code and telephone number	Conditional	If patient is not the insured, enter the insured's address (apartment/PO box number, street, city, state, zip code) and telephone number with area code.
8	Patient status	Not required	Place an "X" in the box indicating the client's marital status and an "X" in the box indicating whether client is employed or a full/part-time student.
9	Other insured's name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the name (last name, first name, middle initial) of the person who is insured under other payer.
9a	Other insured's policy or group number	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's policy or group number or the insured's identification number.

9b	Other insured's date of birth	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the date of birth in MMDDYY format and put an "X" in the box indicating the other insured's gender.
9c	Other insured's employer's name or school name	Not required	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's employer's name. If another payer is involved and the other insured is eligible by virtue of employment or a policy provided through a school that they are attending, enter the name of the school or employer.
9d	Other insured's insurance plan name or program name	Conditional	Required if Field 11d is marked "yes" or if there is other insurance involved with the reimbursement of this claim. Enter the other insured's insurance company or program.
10	Is the patient's condition related to: employment? Auto accident? Other accident?	Not Required	Place an "X" in the box indicating whether or not the condition for which the client is being treated is related to current or previous employment, an automobile accident or any other accident. Enter an "X" in either the YES or NO box for each question.
10d	Reserved for local use	Not required	Please leave blank.
11	Insured policy group or FECA number	Not required	Insured's group number.
11a	Insured's date of birth	Conditional	Required if the client is not the insured. Enter in MMDDYY format.
11b	Employer name or school name	Not required	Enter the insured employer's name. If the insured is eligible by virtue of employment or covered under a policy as a student, enter the employer or school name.
11c	Insurance plan name or program name	Not Required	Enter the insured's insurance company or program name.
11d	Is there another health benefit plan?	Required	Place an "X" in the box indicating whether there may be other insurance involved in the reimbursement of this claim.

12 & 13	Patient's or authorized person's signature	Required	The patient **must** sign and date the claim if authorizing the release of medical information and/or if authorizing payment to the undersigned physician/supplier/organization listed below. If "signature on file" is indicated, the provider **must** maintain a signed release form or CMS-1500 (HCFA 1500) form.
Provider / Supplier Information (Fields 14 - 33)			
14	Date of current illness, injury or pregnancy	Not required	Not applicable.
15	If patient has had same or similar illness, give first date	Not required	Not applicable.
16	Dates patient unable to work in current occupation	Conditional	Required if the client is eligible for disability or worker's compensation benefits due to this illness. Write the "From" and "To" dates the client was unable to work in MMDDYY format.
17	Name of referring physician or other source	Not required	Not applicable.
17a	ID number of referring physician	Not required	Not applicable.
18	Hospitalization dates related to current services	Not required	Print the admission and discharge dates for services related to a hospitalization.
19	Reserved for local use	Not required	Not applicable.
20	Outside lab/charges	Not Required	Enter if lab tests performed and billed on this claim were processed by a lab outside the provider's premises.
21.1	Diagnosis or nature of illness or injury	Required	Enter a valid ICD-9 diagnosis code (include fourth and fifth digits if applicable) that describes the principal diagnosis for services rendered. Please exclude the decimal point.
21.2-4	Diagnosis or nature of illness or injury	Conditional	If there are additional diagnoses, enter a valid ICD-9 diagnosis code (include fourth and fifth digits if applicable) that describes additional diagnoses for services rendered. Please exclude the decimal point.

22	Medicaid resubmission code/original reference number	Not required	Not applicable.
23	Prior authorization number	Not required	Print the prior authorization number.
24a	Dates of service	Required	Enter "Form" and "To" dates of service in MMDDYY format. Line items can include no more than one date of service for the same procedure code.
24b	Place of service	Required	Enter the appropriate HCFA place of service code.
24c	Type of service	Not required	Print the appropriate type-of-service code.
24d	Procedures, services or supplies: CPT/HCPCS	Required	Enter a valid CPT or HCPCS code for each service rendered.
24d	Procedures, services or supplies: modifier	Conditional	Enter a valid CPT or HCPCS code modifier for each service entered.
			HIPAA Billing Code Modifiers
			When submitting a CPT or HCPCS code with a modifier, it is critical that the modifier be placed in its appropriate allocation. HIPAA allows up to four (4) modifiers to be used. The order of the modifiers has a particular meaning. The order of the modifiers is found below.
			#1 Modifier - This field is dedicated for modifiers that affect or define the service (e.g.,TG modifier to identify a 'complex high level of care')
			#2 Modifier - This field is dedicated for modifiers that identify pricing (e.g., HN modifier to identify 'bachelors level').

			#3 - #4 Modifiers - These fields are dedicated for modifiers that identify statistics (e.g., HV - 'funded by State Addictions Agency'
			If you have any questions regarding the use of Modifiers, call ABH's Provider Relations Department.
24e	Diagnosis code	Required	Enter the number (1,2,3,4) of the diagnosis code entered in Field 21 for which this service was rendered. Do not enter the ICD-9 diagnosis code.
24f	Charges	Required	Enter the provider's billed charges.
24g	Days or units	Required	Enter the appropriate number of units or days that correspond to the "Form" and "To" dates indicated in Field 24a.
24h	EPSDT family plan	Not required	If service was rendered as part of or in response to an EPSDT panel, mark and "X" in this block.
24i	EMG	Not required	Not applicable
24j	COB	Conditional	Enter a "Y" if another payer has already paid on this service: otherwise, leave blank.
24k	Reserved for local use/other insurance payment	Conditional	Enter the amount paid by the client for this service, otherwise leave blank.
25	Federal Tax ID number and type: Social Security Number or Employer Identification Number	Required	Enter the 9-digit Employee Identification Number (EIN) or Social Security Number under which payment for services is to be made for reporting earnings to the IRS. Enter an "X" in the appropriate box that identifies the type of ID number used for services rendered.
26	Patient's account number	Not required	Enter the unique number assigned by the provider for the patient.
27	Accept Assignment?	Required	Enter an "X" in the appropriate box.
28	Total Charge	Not required	Enter the total charge for this claim. This is the total of all charges or each service noted in Field 24f.

29	Amount paid	Not required	Enter the total amount paid by the patient and/or another payer for services billed on this claim.
30	Balance due	Not required	Enter the total balance due for the services less any amount entered in Field 29.
31	Signature of physician or supplier including degrees or credentials	Required	Signature of physician/therapist/supplier including degree(s) or credentials and date of signature. NOTE: The person rendering care must sign or have the signature on file and indicate licensure level.
32	Name and address of facility where services were rendered	Required	Enter the site name and address and include Vendor ID number.
33	Physician's/supplier's billing: name, address, zip code and phone number	Required	Enter the appropriate billing information.
33	PIN number	Required	Enter the Organization ID number
33	Group number	Required	Enter the Vendor ID number

APPENDIX F: CMS (HCFA) 1500 Reference Material

Place of Service Codes (Field 24B HCFA 1500)

Definition	Code
Office	11
Home	12
School	19
Inpatient hospitalization	21
Outpatient hospitalization	22
Emergency room, hospital	23
Ambulatory surgical center	24
Birthing center/free-standing facility	25
Military treatment facility	26
Skilled nursing facility	31
Nursing facility	32
Custodial care facility	33
Hospice	34
Ambulance, land	41
Ambulance, air or water	42
Federally qualified health center	50
Inpatient psychiatric facility	51
Psychiatric facility partial hospitalization	52
Community mental health center	53
Intermediate care facility/mental retardation	54
Residential substance abuse treatment facility	55
Psychiatric residential treatment center	56
Comprehensive inpatient rehabilitation facility	61
Comprehensive outpatient rehabilitation facility	62
End-stage renal disease treatment facility	65
State or local public health	71
Rural health clinic	72
School	80
Independent laboratory	81
Court	82
Correctional facility	83
Other community setting	84
Drop-in center	85
Foster home	86
Place of employment	87
Other unlisted facility	99

APPENDIX G: CMS (HCFA) 1500 - Professional Ambulatory Codes
Standard OP-BEH Auth

CPT Code	Description
90804	Individual Therapy - (20-30 min.)
90805	Individual Therapy w/ Med Management (20-30 min.)
90806	Individual Therapy (45-50 min.)
90807	Individual Therapy w/ Med Management (45-50 min.)
90846	Family Therapy without patient
90847	Family Therapy with patient
90853	Group Therapy
90862	Psychopharmacology Management
90875	Individual Psychophysiological Therapy w/Biofeedback (20-30 min.)
90876	Individual Psychophysiological Therapy w/Biofeedback (45-50 min.)
90880	Medical Hypnotherapy
99241	Office or Other Outpatient Consultation (15 min.)
99242	Office or Other Outpatient Consultation (30 min.)
99243	Office or Other Outpatient Consultation (40 min.)
99244	Office or Other Outpatient Consultation (60 min.)
99245	Office or Other Outpatient Consultation (80 min.)
99251	Inpatient Consultation (20 min.)
99252	Inpatient Consultation (40 min)
99253	Inpatient Consultation (55 min.)
99254	Inpatient Consultation (80 min.)
99255	Inpatient Consultation (110 min.)
99261	Follow-up Inpatient Consultation (10 min.)
99262	Follow-up Inpatient Consultation (20 min.)
99263	Follow-up Inpatient Consultation (30 min.)
99271	Confirmatory Consultation, Focused
99272	Confirmatory Consultation, Expanded
99273	Confirmatory Consultation, Detailed
99274	Confirmatory Consultation, Comprehensive, Moderate Complexity
99275	Confirmatory Consultation, Comprehensive, High Complexity

APPENDIX H: CMS (HCFA) 1500 - Professional Ambulatory Codes Requiring Special Authorization

CPT Code	Description
90801	Initial Psychiatric Interview Examination
90870	Electroconvulsive Therapy, Single Seizure
90871	Electroconvulsive Therapy, Multiple Seizures
90899	Unlisted Psychiatric Service or Procedure
96100	Psychological Testing
96115	Neurobehavioral Status Exam
96117	Neuropsychological Testing Battery

APPENIDX I: CMS (HCFA) 1500 – Procedure Codes for All Other Levels of Care Requiring Authorization

Psychiatric Services

Service	DMHAS LOC	CMS 1500 Procedure Code
Partial Hospitalization	MH II.5	H0035
Intensive Outpatient MH	MH II.1	S9480

Substance Abuse Services

Service	DMHAS LOC	UB-92 Revenue Code
Residential Detox – Medically Managed	SA III.7-D	H0011
Intensive Residential – Level III.7	SA III.7	H0018
Residential Long Term Care	SA III.3	H0019
Observation / Flex Bed	SA II.7	H0010, H0047
Partial Hospitalization	SA II.5	S0201
Intensive Outpatient SA	SA II.1	H0015
Ambulatory Detox w/ On-Site Monitoring	SA II.D	H0013, H0014
Ambulatory Detox	SA I.D	S9475, 00190
Methadone Maintenance	SA I.3	H0020
Methadone Detox	SA I.2	H0012, 00509