CMS 1500 THIRD-PARTY LIABILITY CLAIM INSTRUCTIONS

OVERVIEW

The following is a block-by-block explanation of how to prepare a CMS 1500 with third-party liability (TPL) claim. If the primary payer is Medicare, please refer to CMS 1500 Medicare Crossover Claim Instructions. If Medicaid is the only payer or primary payer refer to the CMS 1500 Claim Instructions.

Mandatory blocks must be completed. Conditionally mandatory blocks must be completed if applicable. Please do not write or type above block 1 of the claim form. It is used internally by South Dakota Medicaid. Do not put social security numbers on the claim form.

A provider must attach the Explanation of Medicare Benefits (EOMB) and any applicable third-party explanation of benefits (EOB) to each TPL claim form. TPL claims cannot be processed without an EOMB.

SD Medicaid will require the Servicing Provider to submit the following documentation when the recipient's third-party liability plan does not cover providers credentialed for South Dakota Medicaid:

- Letter stating credentials of Servicing Provider for claim date of service(s).
- Dated credentialing information from applicable recipient's third-party liability plan handbook or policy manual that states the Servicing Provider is ineligible to enroll. If a policy manual is not available, the Servicing Provider must seek a dated credentialing denial confirming the provider is ineligible to enroll due to licensure.

Documentation must accompany every claim that is submitted.

CLAIM INSTRUCTIONS

BLOCK 1 HEADINGS
Place an "X" or check mark in the Medicaid block. If left blank, Medicaid will be considered the applicable program.

BLOCK 1a INSURED'S ID NO. (MANDATORY)
The recipient identification number is the nine-digit number found on the South Dakota Medicaid Identification Card. The three-digit generation number that follows the nine-digit recipient number is not part of the recipient's ID number and should not be entered on the claim. Do not enter a social security number.

BLOCK 2 PATIENT'S NAME (MANDATORY)
Enter the recipient's information in the following format: last name, first name, middle initial. Example: Doe, Jane, S

If there is a suffix, please enter after the last name. Example: Doe, Jr, John, S

The recipient's name must match the name on the recipient's Medicaid ID and the online portal.

BLOCK 3 PATIENT'S DATE OF BIRTH
If available, please enter in this format; MM-DD-YY.

PATIENT'S SEX
Optional

BLOCK 4 INSURED'S NAME
Optional

BLOCK 5 PATIENT'S ADDRESS
Optional

BLOCK 6 PATIENT'S RELATIONSHIP TO INSURED
Optional

BLOCK 7 INSURED'S ADDRESS
Optional

BLOCK 8 PATIENT STATUS
Optional

BLOCK 9 OTHER INSURED'S NAME (CONDITIONALLY MANDATORY)
If the recipient has more than one other insurance coverage, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known

Do not enter Medicare, PHS, or IHS. Please refer to the CMS 1500 Medicare Crossover Claim Instructions or the CMS 1500 Claim Instructions for PHS or IHS.

BLOCK 10 CONDITION RELATED TO
A. Patient's Employment – If the patient was treated due to employment-related accident, place an "X" in the "YES" block, if not, place an "X" in the "NO" block or leave blank.

B. Auto accident-If the patient was treated due to an auto accident, place an "X" in the in the "YES" block, if not, place an "X" in the "NO" block or leave blank. If "YES", put the state abbreviation under the "PLACE" Line. The "PLACE" identifier is optional.

C. Other accident- If other type of accident, place an "X" in the "YES" block, if not, place an "X" in the "NO" block or leave blank.

D. Claim Codes-Enter one of the following, if applicable:
"U" for Urgent Care

BLOCK 11 INSURED'S POLICY GROUP OR FECA NUMBER (CONDITIONALLY MANDATORY)
If the recipient has other health insurance coverage (example: auto insurance, private health insurance or school insurance) provide the requested information in blocks 11, 11a, 11b, 11c, if known. Do not include IHS in this block. If the recipient has more than one other insurance coverage check "YES" block 11d. If "YES" is checked in block 11d, provide the requested information in blocks 9, 9a, 9b, 9c, and 9d, if known. Do not include social security numbers.

BLOCK 12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
Optional

BLOCK 14 DATE OF CURRENT ILLNESS
Optional

BLOCK 15 IF PATIENT HAS HAD SAME ILLNESS OR SIMILAR ILLNESS
Optional

BLOCK 16 DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
Optional

BLOCK 17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE AND THE NUCC CODE (CONDITIONALLY MANDATORY)
Please view NPI Requirements by provider type for ordered, referred, and prescribed services here (ORP Table). If the service was ordered, referred, or prescribed, enter the ordering, referring, or prescribing physician's (or other sources) NUCC defined qualifier code followed by the provider name:

DN Referring Provider
DK Ordering Provider
DQ Supervising Provider

17a. Leave Blank

17b. (CONDITIONALLY MANDATORY) Enter the NPI number of the ordering, referring, or prescribing provider listed in Block 17.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.		
DK	John Q. Public	17b.	NPI	1987654321

BLOCK 18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
Optional

BLOCK 19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
MANDATORY for Transportation Providers
Transportation claims must list the origin and destination in this block. This block may also be used for additional information.

BLOCK 20 OUTSIDE LAB
Optional

BLOCK 21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (MANDATORY)
Enter "0" for ICD-10-CM.

Enter the codes on each line (A-L) to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code. The first diagnosis code listed will be the primary diagnosis, followed by all other diagnosis codes. List no more than 12 diagnosis codes.

BLOCK 22 MEDICAID RESUBMISSION NUMBER **(MANDATORY FOR ADJUSTMENTS AND VOIDS ONLY)**
This box must be left blank unless submitting an adjustment or void. Any inessential mark may cause the claim to process incorrectly. For information on submitting a void or adjustment please refer to CMS 1500 Void and Adjustment Instructions.

BLOCK 23 **PRIOR AUTHORIZATION NUMBER (CONDITIONALLY MANDATORY)**
Enter the South Dakota Medicaid prior authorization number if applicable. Otherwise, leave this box blank.

BLOCK 24 List only one servicing provider on each CMS 1500 claim form. Use a separate line for each service provided. If more than six services were provided for a recipient, a separate claim form for the seventh and any additional services must be completed. The six service lines in this section are divided horizontally to accommodate submission of both the NPI and taxonomy code in 24J. The top shaded portion is the location for the reporting supplemental information. It is not intended to allow the billing of 12 lines of service.

SHADED PORTION OF BLOCK 24
The order of the information entered in the shaded portion does not matter. The shaded portion is considered one block starting at 24A shaded through 24H shaded.

1. When billing with third party liability data, enter the contractual obligation (CTR) and payment in the shaded portion. If this amount is equal to zero, indicate this on the

claim by entering in this format with no spaces CTR0.00. After listing CTR enter three spaces and then the payment amount. When reporting dollar amounts in the shaded area always enter dollar amount, a decimal point, and cents. Use 00 for the cents if the amount is a whole number. Do not enter dollar signs.
FQHC and RHC <u>services only need to indicate the total TPL payment on the first line.</u>

Example:

	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	CTR 0.00			50.00															ZZ	123Z00000X
	01	01	19	01	01	19	03		95831					D	236	96	1		NPI	1234567891

If using a drug-related procedure code, enter the N4 qualifier code followed by the 11-character NDC with no hyphens or spaces, the unit of measure qualifier and quantity in the shaded area above the dates of service. Use one of the following units of measure (must be uppercase).

F2 = International Unit
GR = Gram
ME = Milligram
ML = Milliliter
UN = Unit

Please view additional guidance for NDC billing here.

Example:

	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	CTR 50.00			20.00					N461786060866										ZZ	123Z00000X
	01	01	19	01	01	19	03		J1200					E	156	96	1		NPI	1234567890

UNSHADED PORTION OF BLOCK 24

A. DATE OF SERVICE FROM – TO (MANDATORY)

Enter the appropriate date of service in month, day, and year sequence, using six digits in the unshaded portion. If billing a lab code, the date of service is the date the specimen was drawn.

	From	To
Example:	010119	010119

B. **PLACE OF SERVICE (MANDATORY)**

Enter the appropriate place of service code.

Code values:

01 Pharmacy
02 Telehealth
03 School

04	Homeless Shelter
05	IHS Free-standing Facility
06	IHS Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison/Correctional Facility (Not covered)
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-In Retail Health Clinic
18	Place of Employment – Worksite
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room-Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance-Land
42	Ambulance-Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Intellectual Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
57	Nonresidential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End-Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

C. EMG
Enter a "Y" to indicate an emergency, otherwise leave blank.

D. PROCEDURE CODE (MANDATORY)
Enter the appropriate five characters Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) procedure codes for the service provided. Enter the appropriate procedure modifier, if applicable. Use the same procedure code only once per date of service. A procedure code may be listed more than once per date of service if an applicable modifier is included.

If using a drug-related HCPCS code, you must enter the NDC code (refer to Block 24-Shaded). Click here for the Noridian Crosswalk.

Other Provider Preventable Conditions (OPPC) must be billed with a modifier. OPPC includes surgery on the wrong patient, wrong surgery on a patient, and wrong site surgery. OPPCs can occur in any care setting and should can be billed on CMS 1500. Below are the procedure code modifiers that must be billed as the primary modifier by the facility/provider that performed the service, if applicable:

- "PB" Surgical or other invasive procedure on wrong patient
- "PC" Wrong surgery or other invasive procedure on patient
- "PA" Surgical or other invasive procedure on wrong body part

E. DIAGNOSIS POINTER (MANDATORY)
Enter the reference letter (A – L) which corresponds to the applicable diagnosis code(s) entered in Block 21. The Diagnosis Pointer relates to the reason the service was performed. A maximum of four diagnosis pointers may be entered per line. Do not enter the diagnosis code in 24E.

F. CHARGES (MANDATORY)
Enter the provider's usual and customary charge for this service or procedure in the unshaded portion. For example, if the usual and customary charge is $50.00 enter 50 to the left of the dotted line, with no dollar sign. Enter 00 to the right of the dotted line.

If billing more than one unit of a procedure code, enter the total charges for all units of the procedure code being billed. For example, if the usual and customary charge is $50.00 a unit and five units are being billed enter 250.00.

Example:

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 CTR 50.00			20.00					N461786060866						ZZ	123Z00000X
01	01	19	01	01	19	03		J1200		E	250 00	5		NPI	1234567890

G. DAYS OR UNITS (MANDATORY)

Enter the number of units or times that the procedure or service was provided for this recipient during the period covered by the dates in block 24a.

This must be a whole number. Partial numbers and decimals will not be accepted and may result in denials or incorrect payments. Billed units shall not exceed 999. Date spans where the units exceed 999 must be split into two separate lines with non-overlapping dates.

H. **EPSDT – FAMILY PLANNING (CONDITTIONALLY MANDATORY)**

If services were provided because of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) referral, enter an "E" in the unshaded portion of the field, if not, leave blank.

Enter an "F" in the unshaded portion of the field if billing for family planning visits, medication, devices, or surgical procedures.

For more information regarding Family Planning, please refer to the Family Planning Manual.

I. ID. QUAL (CONDITIONALLY MANDATORY)

Enter ZZ in the shaded portion of 24I when populating shaded portion of 24J with a taxonomy code.

J. TAXONOMY AND RENDERING PROVIDER ID # (CONDITIONALLY MANDATORY)

1. **Shaded Portion:** Enter the taxonomy code in the shaded portion of the field. A Type 1 NPI is an NPI for a person. When billing with a Type 1 NPI the individual's associated servicing taxonomy code is required in the shaded portion of 24J.

   A Type 2 NPI is an entity/organization NPI. When billing with a Type 2 NPI the entity's billing taxonomy code is required.

2. **Unshaded Portion:** Enter the appropriate ten-byte NPI number.

The NPI requirements for each provider type are available here.

BLOCK 25 FEDERAL TAX ID NUMBER (MANDATORY)

Enter the number assigned to the provider by the federal government for tax reporting purposes. This is also known as a tax identification number (TIN) or employer identification number (EIN).

BLOCK 26 PATIENT'S ACCOUNT NO.
Optional. Enter your office's patient account number, up to ten numbers, letters, or a combination thereof is allowable. Examples: AMX2345765, 9873546210 and YNXDABNMLK. Information entered here will appear on your Remittance Advice when payment is made.

BLOCK 27 ACCEPT ASSIGNMENT
Leave blank. South Dakota Medicaid can only pay the provider.

BLOCK 28 TOTAL CHARGES
Optional

BLOCK 29 AMOUNT PAID (MANDATORY)
If payment was received from a third-party such as private health insurance, enter the sum of all payment amounts identified in the shaded area of 24a through 24f. Do not add the CTR amount or Medicaid's cost share (recipient payment) to this total. Do not subtract the third-party payment from your charge. If payment was denied or if paid zero (ex: deductible or coinsurance), enter 0.00. Attach a copy of the third party's remittance advice or explanation of benefits behind each claim form.

BLOCK 30 BALANCE DUE
Optional

BLOCK 31 SIGNATURE OF PHYSICIAN OR SUPPLIER (MANDATORY)
The claim form must be signed by the provider or provider's authorized representative, using handwriting, typewriter, signature stamp, or other means. Enter the date that the form is signed.

BLOCK 32 SERVICE FACILITY LOCATION INFORMATION
Enter name, address, city, state, and nine-digit zip code, including the hyphen of the location where services were rendered.
32a. Enter the NPI number of the service facility location or rendering provider.
32b. Enter the qualifier code "ZZ" along with the associated taxonomy code.

BLOCK 33 BILLING PROVIDER INFO & PHONE # (MANDATORY)
Enter information regarding the provider that is requesting to be paid for services rendered. Enter the billing provider's name and mailing address as shown on the provider's South Dakota Medicaid enrollment record. The telephone number is optional but is helpful if a problem occurs during processing of the claim.

ID NO.

33a. Enter the billing NPI number of the billing provider.
If you are enrolled as a Regular Individual Provider, you may use your servicing NPI in 33a.

33b. Enter ZZ along with the entity's billing provider taxonomy code that is associated with the NPI in 33a. Do not enter a space, hyphen, or other separator between the qualifier and number.

Claims of unenrolled billing NPIs cannot be processed. Please ensure that your billing NPI is active for the date of service on the claim.

QUICK ANSWERS

1. **If primary insurance doesn't make payment, do I still have to include information in Block 24?**

   Yes, this information is required for the claim may not correctly pay.

2. **If primary insurance does not cover a specific service, do I still have to submit to the primary?**

   Yes, documentation must be provided to support coordination of benefits.

3. **What do I do if the recipient advises that his or her primary insurance is no longer active?**

   The recipient needs to contact South Dakota Medicaid at 1-800-597-1603 to update their file.

4. **What if a recipient fails to tell a provider that they have primary insurance and timely filing for the primary insurance has passed?**

   South Dakota Medicaid will deny the claim.