1. CMS-1500 Billing Guide for PROMISe™ Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

Purpose of the document

The purpose of this document is to provide a block-by-block reference guide to assist the following provider types in successfully completing the CMS-1500 Claim Form:

- **Certified Nurse Midwife**
- **Certified Registered Nurse Practitioners**
- **Hospital Based Clinics**
- **Independent Medical/Surgical Clinics**
- **Physicians**

Document format

This document contains a table with four columns. Each column provides a specific piece of information as explained below:

- **Block Number** – Provides the block number as it appears on the claim.
- **Block Name** – Provides the block name as it appears on the claim.
- **Block Code** – Lists a code that denotes how the claim block should be treated. They are:

  M – Indicates that the claim block must be completed.

  A – Indicates that the claim block must be completed, if applicable.

  O – Indicates that the claim block is optional.

  LB – Indicates that the claim block should be left blank.

  * – Indicates special instruction for block completion.

- **Notes** – Provides important information specific to completing the claim block. In some instances, the Notes section will indicate provider specific block completion instructions.

Message for Hospitals

If hospitals bill for complete EPSDT screens on the UB-04 or in the 837I electronic format, **the Medical Assistance (MA) fee for a complete EPSDT screening will not be received**.

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IMPORTANT INFORMATION FOR CMS-1500 CLAIM FORM COMPLETION

Note #1:   If you are submitting handwritten claim forms you must use **blue** or **black** ink.

Note #2:   **Font Sizes** ─ Because of limited field size, either of the following type faces and sizes are recommended for form completion:

- **Times New Roman, 10 point**
- **Arial, 10 Point**

Other fonts may be used, but ensure that all data will fit into the fields, or the claim may not process correctly.

Note #3:   When completing the following blocks of the CMS-1500, **do not use decimal points and be sure to enter dollars and cents**:

1. Block 24f ($Charges)
2. Block 29 (Amount Paid)

If you fail to enter both dollars and cents, your claim may process incorrectly. For example, if your usual charge is sixty-five dollars and you enter 65, your usual charge may be read as .65 cents.

Example #1:   When completing Block 24f, enter your usual charge to the general public, without a decimal point. You must include the dollars and cents. If your usual charge is fifteen dollars, enter:

24f	
$CHARGES	
15	00

Example #2:   When completing Block 29, you are reporting patient pay assigned by the County Assistance Office (CAO). Enter patient pay as follows, including dollars and cents:

29	
Amount Paid	
50	00

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Complete EPSDT Screens

All providers billing for complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens must bill using the CMS-1500 Claim Form or electronically using the 837P format.

Providers choosing to bill for EPSDT screens via the CMS-1500 Claim Form must bill using all of the individual age-appropriate procedure codes, including immunizations, for a complete screen. Please consult the **Pennsylvania's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program Periodicity Schedule and Coding Matrix (Periodicity Schedule)** and the **Age Range Requirements for Screening Visits Desk Guide** as well as the **Recommended Childhood and Adolescent Immunization Schedules (Immunization Schedules)** for screening eligibility information and the services required to bill for a complete EPSDT screen.

Note: The **Periodicity Schedule** and the **Immunization Schedules** are updated *periodically* and published in Medical Assistance Bulletins (MABs). Please use the most recent schedules when providing EPSDT screens.

Please review the instructions in the billing guide for the following blocks when submitting a claim form for a complete EPSDT screen:

- **Block 10d (Claim codes (Designated by NUCC))** – This Block **MUST** be completed when a referral was made as a result of the screen, including where required according to the Periodicity Schedule. Use the appropriate EPSDT Referral Code(s) when you refer a child to another practitioner as a result of the EPSDT screen.

  Please Note: **The YD referral code for Dental referrals is required for all complete EPSDT screens delivered to children 3 through 20 years of age.**

- **Block 21 (Diagnosis or Nature of Illness or Injury)** – The diagnosis (DX) code in block 21 must be **Z00110**, **Z00111, Z00121, Z00129, Z761, Z762, Z0000 or Z0001** for an EPSDT screen. When applicable, you may enter up to eleven additional diagnosis codes. Please note that you are **not required** to use immunization diagnosis codes.

- **Block 21** also requires the completion of an ICD Indicator. When billing for ICD-10-CM codes, enter a zero (0) in the ICD Ind. space.

- **Block 24h** – Enter Visit Code **03** to indicate that you are billing for an EPSDT service.

The EPSDT complete screen and modifier EP must be reported on the first claim line of Block 24d. Please list all of the required components of an EPSDT screen, which were provided, in Block 24d on lines 2 through 6. If more than six claim lines are necessary to report the components of a

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complete EPSDT screen, **please use two claim forms**. If a second CMS-1500 Claim Form is necessary, use the second CMS-1500 Claim Form to report any additional procedure codes (e.g., immunizations).

The following provides an example of how to complete the CMS-1500 for an EPSDT screen.

Example:

A 4-year old child comes into your office/hospital clinic for an EPSDT screen. As per the Periodicity Schedule, the **required components** for a 4-year EPSDT screen are:

- A periodic preventative medicine evaluation (new patient – Procedure Code 99382) or reevaluation (established patient – Procedure Code 99392);
- Vision screen (Procedure Code 99173, 99174 or 99177),
- Hearing – Audio screen or pure tone-air only (Procedure Code 92551 or 92552)
- Referral to a dental home.

Enter the required components of the EPSDT screen, which were performed.

For example:

- **Claim Line 1, Block 24d** – Enter **99392 EP**
- **Claim Line 2, Block 24d** – Enter **99173**
- **Claim Line 3, Block 24d** – Enter **92551**
- **Block 10d, YD referral code**

Utilize a second CMS-1500 Claim Form if more than six claim lines are required to report the components of the EPSDT screen.

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MA Fee for Complete/ Incomplete EPSDT Screen

The MA fees for complete EPSDT screens are paid by the Department when a complete EPSDT screen has been performed and billed according to the Pennsylvania's EPSDT Program Periodicity Schedule and Coding Matrix, with the appropriate use of modifiers, referral codes and diagnosis codes. Incomplete EPSDT screens may be paid at the MA Program Fee Schedule rate for the complete screen (as represented by the MA Program Fee Schedule) and/or MA Program Fee Schedule rate for each component code reported. The combined MA fee for all required individual service components will not equal or exceed the MA fee for a complete EPSDT screen which is assigned to the specific screening period.

Incomplete EPSDT Screens

Incomplete EPSDT screens are office visits where the provider did not complete all of the required components listed on the Periodicity Schedule for the child's screening period. This includes use of applicable modifiers, diagnosis codes and required referral codes.

Independent Medical/Surgical Clinic providers who wish to bill for the office visit components/incomplete EPSDT screen should bill the service as a clinic visit with procedure code T1015, with their pricing modifier U7 and informational modifier EP. This service should also be billed on the CMS 1500 / 837P.

Outpatient hospital clinics wishing to bill individual EPSDT components/incomplete screens should refer to the MA Program Fee Schedule and the **UB-04 Billing Guide for PROMISe™ Hospitals** for instructions.

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You must follow these instructions to complete the CMS-1500 Claim Form when billing the Department of Human Services. **Do not imprint, type, or write any information on the upper right hand portion of the form.** This area is used to stamp the Internal Control Number (ICN), which is vital to the processing of your claim. Do not submit a photocopy of your claim to DHS.

Block No.	Block Name	Block Code	Notes
1	Type of Claim	M	Place an **X** in the Medicaid box.
1a	Insured's ID Number	M	Enter the 10-digit beneficiary number found on the ACCESS card. If the beneficiary number is not available, access the Eligibility Verification System (EVS) by using the beneficiary's Social Security Number (SSN) and date of birth (DOB). The EVS response will then provide the 10-digit beneficiary number to use for this block.
2	Patient's Name	A	It is recommended that this field be completed to enable Medical Assistance (MA) to research questions regarding a claim. ***This field is required when billing for newborns using the mother's patient number.** Enter the newborn's name. If the first name is not available, you are permitted to use Baby Boy or Baby Girl.
3	Patient's Birthdate and Sex	A	Enter the patient's date of birth using an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 02151978) and indicate the patient's gender by placing an **X** in the appropriate box. ***Same as the special instruction for Block 2.** Enter the newborn's date of birth in an eight-digit format.
4	Insured's Name	A	If the patient has health insurance other than MA, list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word **SAME** may be entered. If there is no other insurance other than MA, leave this block blank.
5	Patient's Address	O	Enter the patient's address.

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Block No.	Block Name	Block Code	Notes
6	Patient's Relationship to Insured	A	Check the appropriate box for the patient's relationship to the insured listed in Block 4.
7	Insured's Address	A	Enter the insured's address and telephone number except when the address is the same as the patient's, then enter the word **SAME**. Complete this block only when Block 4 is completed.
8	Reserved for NUCC Use	LB	Do not complete this block.
9	Other Insured's Name	A	If the patient has another health insurance secondary to the insurance named in Block 11, enter the last name, first name, and middle initial of the insured if it is different from the patient named in Block 2. If the patient and the insured are the same, enter the word **SAME.** If the patient has MA coverage only, leave the block blank.
9a	Other Insured's Policy or Group Number	A	This block identifies a secondary insurance other than MA, **and** the primary insurance listed in 11a–d. Enter the policy number and the group number of any secondary insurance that is available. Only use Blocks 9, 9a and 9d, if you have completed Blocks 11a, 11c and 11d , and a secondary policy is available. (For example, the patient may have both Blue Cross and Aetna benefits available.)
9b	Reserved for NUCC Use	LB	Do not complete this block.
9c	Reserved for NUCC Use	LB	Do not complete this block.
9d	Insurance Plan Name or Program Name	A	Enter the other insured's insurance plan name or program name.

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Block No.	Block Name	Block Code	Notes
10a-10c	Is Patient's Condition Related To:	A	Complete the block by placing an **X** in the appropriate **YES** or **NO** box to indicate whether the patient's condition is related to employment, auto accident, or other accident (e.g., liability suit) as it applies to one or more of the services described in Block 24d. For auto accidents, enter the state's two-digit postal code for the state in which the accident occurred in the PLACE block (e.g., PA for Pennsylvania).
10d	Claim Codes (Designated by NUCC)	A	**This Block MUST be completed** when a referral was made as a result of the screen, including where required according to the Periodicity Schedule. This block is used for federal reporting purposes. **Please note: The YD referral code for Dental referrals is required for all complete EPSDT screens delivered to children 3 through 20 years of age.** Enter the applicable two-character EPSDT Referral Code in UPPERCASE / CAPITAL LETTERS for referrals made or needed as a result of the screen: **YM** – Medical Referral **YD** – Dental Referral **YV** – Vision Referral **YH** – Hearing Referral **YB** – Behavioral Health Referral **YO** – Other Referral For a complete listing and explanation of EPSDT Referral Codes, please refer to the *CMS-1500 Claim Form Desk Reference*, located in Appendix A of the handbook.
11	Insured's Policy Group or FECA Number	A/A	Enter the policy number and group number of the primary insurance other than MA.

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Block No.	Block Name	Block Code	Notes
11a	Insured's Date of Birth and Sex	A/A	Enter the insured's date of birth in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03011978) and insured's gender if it is different than Block 3.
11b	Other Claim ID (Designated by NUCC)	LB	Do not complete this block.
11c	Insurance Plan Name or Program Name	A	List the name and address of the primary insurance listed in Block 11.
11d	Is There Another Health Benefit Plan?	A	If the patient has another resource available to pay for the service, bill the other resource before billing MA. If the **YES** box is checked, Blocks 9, 9a and 9d must be completed with the information on the additional resource.
12	Patient's or Authorized Person's Signature and Date	M/M	The patient's signature or the words **Signature Exception** must appear in this field. Also, enter the date of claim submission in an 8-digit MMDDCCYY format (e.g., 03012004) with no slashes, hyphens, or dashes. **Note:** Please refer to Section 6 of the PA PROMIS*e*™ Provider Handbook for the 837 Professional/CMS-1500 Claim Form for additional information on obtaining patients signatures.
13	Insured's or Authorized Person's Signature	O	If completed, this block should contain the signature of the insured, if the insured is not the patient.
14	Date of Current Illness, Injury or Pregnancy (LMP)	O	If completed, enter the date of the current illness (first symptom), injury (accident date), or pregnancy in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012004).

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Block No.	Block Name	Block Code	Notes
15	Other Date	O	If the patient has had the same or similar illness, list the date of the first onset of the illness in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012002).
16	Dates Patient Unable to Work in Current Occupation	O	If completed, enter the **FROM** and **TO** dates in an eight-digit MMDDCCYY (month, day, century, and year) format (e.g., 03012003), only if the patient is unable to work due to the current illness or injury. This block is only necessary for Worker's Compensation cases. It must be left blank for all other situations.
17	Name of Referring Provider or Other Source	A	Enter the name and degree of the referring or prescribing practitioner, when applicable.
17a	I.D. Number of Referring Provider	A	In the first portion of this block, enter a two-digit qualifier that indicates the type of ID: **0B** = License Number **G2** = 13-digit Provider ID number (Legacy Number) In the second portion, enter the **<u>license number</u>** of the referring or prescribing practitioner named in Block 17 (e.g., MD123456X). If the practitioner's license number was issued after June 29, 2001, enter the number in the new format (e.g., MD123456). If an out-of-state provider orders the service, enter the two-letter State abbreviation, followed by six "9"s, and an "X". For example, a prescribing practitioner from New Jersey would be entered as NJ999999X.
17b	NPI #	M	Enter the 10-digit National Provider Identifier number of the referring provider, ordering provider, or other source.
18	Hospitalization Dates Related to Current Services	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
19	Additional Claim Information (Designated by NUCC)	A/A	This field must be completed with attachment type codes, when applicable. Attachment type codes begin with the letters "**AT**" followed by a two-digit number (i.e., **AT05**). Enter up to four, 4-character alphanumeric attachment type codes. When entering more than one attachment type code, separate the codes with a comma (,). When using "**AT05**" indicating a Medicare payment, please remember to properly complete and **attach** the "Supplemental Medicare Attachment for Providers" form MA 539 . When using "**AT10**" indicating a payment from a Commercial Insurance, please remember to properly complete and **attach** the "Supplemental Attachment for Commercial Insurance for Providers" form MA 538 . Attachment Type Code "**AT99**" indicates that remarks are attached. Remarks must be placed on an 8-1/2" x 11" sheet of white paper clipped to your claim. Remember, when you have a remarks sheet attached, include your provider number and the beneficiary's number on the top left-hand corner of the page (i.e., Enter **AT26, AT99** if billing for newborns that have temporary eligibility under the mother's beneficiary number. On the remarks sheet, include the mother's full name, date of birth, and social security number.). If submitting an adjustment to a previously paid CMS-1500 claim (as referenced in Block 22), you must paper clip an 8-1/2" by 11" sheet of paper to the paper claim form containing an explanation as to why you are submitting the claim adjustment. For a complete listing and description of Attachment Type Codes, please refer to the *CMS-1500 Claim Form Desk Reference*, located in Appendix A of the handbook. *For additional information on completing CMS-1500 Claim Form adjustments, please refer to Section 2.10 – Claim Adjustments of the 837 Professional/CMS-1500 Claim Form Handbook.*
		A	**Qualified Small Businesses**

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Block No.	Block Name	Block Code	Notes
			Qualified small businesses must <u>always</u> enter the following message in Block 19 (Additional Claim Information (Designated by NUCC)) of the CMS-1500, in addition to any applicable attachment type codes: "**(Name of Vendor) is a qualified small business concern as defined in 4 Pa Code §2.32.**"
			Note: If the beneficiary has coverage through Medicare Part B and MA, this claim should automatically cross over to MA for payment of any applicable deductible or co-insurance. If the claim does not cross over from Medicare and you are submitting the claim directly to MA, enter **AT05** in Block 19 and attach a completed "Supplemental Medicare Attachment for Providers" form to the claim. Please refer to MA 539 for additional information.
20	Outside Lab	LB	Do not complete this block.
21	Diagnosis or Nature of Illness or Injury	M/A	**When billing for EPSDT screens,** diagnosis (DX) code Z00110, Z00111, Z00121, Z00129, Z761, Z762, Z0000 or Z0001 (Routine Infant or Child Health Check) must be used in this block. **EXCEPTION** when billing for newborns in an inpatient setting (Place of Service 21). Please <u>use diagnosis code Z3800, Z3801, Z381, Z382 or Z3830-Z388 in the primary field</u> with Z00110, Z00111, Z00121, Z00129, Z761 or Z762 in the secondary field when submitting an EPSDT screen performed in an inpatient hospital setting. The ICD indicator (ICD Ind) is required. If a valid "0" indicator is not entered into the ICD Ind. space, claims will be returned to the provider as incomplete. For dates of service **on or after** October 1, 2015, enter the ICD-10-CM code (indicator "0") that describes the diagnosis. The primary diagnosis block (21.A) must be completed. The second through twelfth diagnosis codes (B-L) must be completed if applicable. An appropriate diagnosis code must be included for each referral.

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Block No.	Block Name	Block Code	Notes
			When reporting the administration of preventative pediatric immunizations, the appropriate CPT code is required along with the diagnosis code Z23 (Need for prophylactic vaccination against bacterial, viral, and other communicative diseases).
22	Resubmission Code	A/A	This block has two uses: 1) When resubmitting a rejected claim. If resubmitting a rejected claim, enter the 13-digit internal control number (ICN) of the **ORIGINAL** rejected claim in the right portion of this block (e.g., | 1103123523123). 2) When submitting a claim adjustment for a previously approved claim**.** If submitting a claim adjustment, enter ADJ in the left portion of the block and the **LAST APPROVED** 13-digit ICN, a space and the 2-digit line number from the RA Statement in the right portion of the block (e.g., ADJ | 1103123523123 01).
23	Prior Authorization Number	LB	Do not complete this block.
24a	Date(s) of Service	M/M	Enter the applicable date(s) of service. If billing for a service that was provided on one day only, complete either the From or the To column (but not both.). If the same service was provided on consecutive days, enter the first day of the service in the From column and the last day of service in the To column. Use an eight-digit (MMDDCCYY) format to record the From and To dates, (e.g. 03012004). If the dates are not consecutive, separate claim lines must be used.
24b	Place of Service	M	Enter the two-digit place of service code that indicates where the service was performed. **11** – Office **21** – Inpatient Hospital **22** – Outpatient Hospital

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Block No.	Block Name	Block Code	Notes
			49 – Independent Clinic
24c	EMG	LB	Do not complete this block.
24d	Procedures, Services, or Supplies (CPT/HCPCS & Modifier)	M/A/A	Review the applicable CPT code(s) for all services provided. Refer to the Periodicity Schedule and Coding Matrix for all required components of a complete EPSDT screen.
			The EPSDT complete screen and modifier EP must be reported on the first line. List the remaining procedure code(s) for the service(s) being rendered and any applicable modifier(s) on the remaining lines.
			In the second and third sections of the block, enter up to four applicable modifiers.
			If you were unable to provide a required service, please use the appropriate procedure code with modifier 52. Providers should make every effort possible to complete that service at the next screening opportunity.
			If you have referred a child to an outside laboratory, please use the appropriate procedure code with modifier 90.
			Note: For all procedure codes reported with modifiers 52 or 90, a zero dollar ($0) billed amount must be reported.
			For compensable procedure code modifier combinations, please refer to the PA PROMISe™ fee schedule accessible via the DHS Internet site.
24e	Diagnosis Pointer	M	This block may contain up to four letters.
			Enter the corresponding letter(s) (A – L) that identify the diagnosis code(s) in Block 21.
			If the service provided was for the primary diagnosis (in Block 21A), enter A. If provided for the secondary diagnosis, enter B. If provided for the third through twelfth diagnosis, enter the letter that corresponds to the applicable diagnosis.

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Block No.	Block Name	Block Code	Notes
			Note: The primary diagnosis pointer must be entered first.
24f	$Charges	M	Enter your usual charge to the general public for the service(s) provided. If billing for multiple units of service, multiply your usual charge by the number of units billed and enter that amount. For example, if your usual charge is sixty-five dollars, enter **6500**.
24g	Days or Units	M	Enter the number of units, services, provided.
24h	EPSDT/Family Planning	A	**Enter Visit Code 03 when providing EPSDT screening services.**
24i	ID Qualifier	A	Enter the two-digit ID Qualifier: **G2** = 13-digit Provider ID Number (legacy #)
24j (a)	Rendering Provider ID #	A	Complete with the **Rendering Provider's** Provider ID number (nine-digit provider number and the applicable four-digit service location – 13-digits total). **Note**: Only one rendering provider per claim form.
24j (b)	NPI	M	Enter the 10-digit NPI number of the rendering provider.
25	Federal Tax I.D. Number	M	Enter the provider's Federal Tax Employer Identification Number (EIN) or SSN and place an **X** in the appropriate block.
26	Patient's Account Number	O	**Use of this block is strongly recommended**. It can contain up to ten alpha, numeric, or alphanumeric characters and can be used to enter the patient's account number or name. Information in this block will appear in the first column of the Detail Page in the RA Statement and will help identify claims if an incorrect patient number is listed.
27	Accept Assignment	LB	Do not complete this block.

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Block No.	Block Name	Block Code	Notes
28	Total Charge	LB	Do not complete this block.
29	Amount Paid	LB	Do not complete this block.
30	Reserved for NUCC Use	LB	Do not complete this block.
31	Signature of Physician or Supplier Including Degree or Credentials	M/M	This block must contain the signature of the provider rendering the service. A signature stamp is acceptable, except for abortions, if the provider authorizes its use and assumes responsibility for the information on the claim. If submitting by computer-generated claims, this block can be left blank; however, a Signature Transmittal Form (MA 307) must be sent with the claim(s). Enter the date the claim was submitted in this block in an eight-digit (MMDDCCYY) format (e.g. 03012004).
32	Service Facility Location Information	LB	Do not complete this block.
32a		LB	Do not complete this block.
32b		LB	Do not complete this block.
33	Billing Provider Info & Ph.#	A/A& M/M	Enter the billing provider's name, address, and telephone number **Do not use slashes, hyphens, or spaces.** **Note:** If services are rendered in the patient's home or facility, enter the service location of the provider's main office.
33a		M	Enter the 10-digit NPI number of the billing provider.
33b		M/A	Enter the 13-digit Group/Billing Provider ID number (Legacy #)