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Deciphering The New CMS 1500 Claim Form

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Q: I am confused on using the new 1500 form, particularly Block 14 and Block 15. What is required and how do I properly fill these out? And do I actually have to use this new form or may I continue using the old version?

A: A new CMS 1500 claim form was released by the U.S. Centers for Medicare and Medicaid Services (CMS). The new CMS-1500 (02/12) will replace the current form (08/05). For Medicare and Medicaid payments the new form was allowed for claims since January 6, 2014, with mandatory use of the newest version on April 1, 2014. Claims sent to Medicare or Medicaid on the old version would be rejected after April 1, 2014.

However each individual payer may use a different time line and could allow use of the older version for a longer period. It is paramount to verify with the plans that you bill regularly, as to their individual time lines and requirements for the newest version. For example, Anthem Blue Cross, United Health Care and Humana simply adopted the Medicare time line and require use now.

Aetna, Blue Shield of California, Cigna and Health Net will accept both versions currently, but will allow only the new version beginning October 1, 2014. I would suggest updating your format and utilizing the new form unless you have specific information that the carrier you are billing will accept the older format.

The new form updated several factors with the most prominent change to block 21 where the diagnosis is listed. In item number 21, the number of lines to report diagnosis codes was increased from 4 to 12, the labels for these lines were changed to letters instead of numbers and the decimal point was removed. The new form allows up to 12 separate diagnoses and is now lettered A-L and from left to right instead of 1-4 and top to bottom. This was done in response to the requirements of ICD-10 (which has been delayed to October 1, 2015) where the diagnosis can be much more specific and require some additional coding.

Additionally, there was an update to blocks 14 and 15 as you noted. A new area was added to the right of Item Number 14 to report a three-digit qualifier, which is intended to indicate which date is being reported - the date of the current illness, injury, or -the date of the last menstrual period. The qualifiers (3 digit number) are as follows. 431 = Onset of Current Symptoms or Illness or 484 = Last Menstrual Period. Clearly this means for your claims the most likely code (unless you are an OB) is 431.

Medicare does not require use of this qualifier but same carriers may. For instance, Anthem has made slew of denials for non-use of the qualifier. As a consequence, I would include the qualifier on the claim except for Medicare. Block 15 updated from "same or similar illness" to "other date" with this date preceded by a qualifier. This is intended to capture another date relevant to the patient's condition or treatment. The area to the left of this field accommodates the reporting of a three-digit qualifier. The date is then reported in the existing date area. The field will accommodate reporting

dates such as initial treatment, accident, last X-ray, and prescription. This block has not been designated as required. 454 Initial Treatment, 304 Latest Visit or Consultation, 453 Acute Manifestation of a Chronic Condition 439 Accident, 455 Last X-ray, or 471 Prescription.

Medicare also does not require use of this block or item. However if you do use this block be sure to include the proper qualifier to identify the specificity of the date.

In addition here is a list of the changes to the newer format:

- All references to Social Security Numbers were removed.
- The following information "Patient Status;" "Other Insured Date of Birth, Sex;" "Employer's Name or School" and "Balance Due" were removed.
- Item 10d was changed from "Reserved for local use" to "Claim Codes (Designated by NUCC)."
- "Employer's Name or School Name" is no longer reported in 11b. A distinct field for reporting a property and casualty claim number was added named, "Other Claim ID (Designated by NUCC)." The area to the left of the line in the left hand side of the field is for reporting a two-digit qualifier that indicates what identifier is being reported. For instance Y4 indicates a "property casualty claim"
- In Item Number 17, the ability to report the role the provider is playing when referring, ordering, or supervising is made possible by listing a two-digit qualifier at the beginning of the line. DN Referring Provider, DK Ordering Provider, or DQ Supervising Provider
- The title for field 19 was changed from "Reserved for Local Use" to "Additional Claim Information (Designated by NUCC)."
- Item Number 22 is now listed as Resubmission and/or Original Reference Number. NUCC states, "List the original reference number for resubmitted claims. Please refer to the most current instructions from the public or private payer regarding the use of this field (e.g., code). When resubmitting a claim, enter the appropriate bill frequency code left justified in the left-hand side of the field. (7 - Replacement of prior claim, 8 - Void/cancel of prior claim.) This Item Number is not intended for use for original claim submissions."
- In Item Number 24E, only four diagnosis codes can be pointed to. In an effort to avoid possible confusion between numbers such as "12" being understood as "1" and "2," the labels for the diagnosis code lines in Item Number 21 are now listed as letters rather than numbers. Item Number 24E will continue to report up to four one-digit diagnosis pointers (listed as letters) from Item Number 21.
- Also in block 21 is designation for ICD "9" indicates the diagnosis codes are from the International Classification of Diseases, Ninth Revision (ICD-9) code set and "0" is for the International Classification of Diseases, Tenth Revision (ICD-10). The use of the indicator will be necessary during the transition to ICD-10 and when reporting services that span the October 1, 2015 implementation deadline. Because only one indicator can be used in this field, the diagnosis codes reported on the form must be all ICD-9 or all ICD-10. Therefore not needed at this time as there is no use of ICD10 and need to make a designation from one to the other.

For further details on the form and a complete manual see this following http://www.nucc.org

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