

The New CMS 1500 Form

- The CMS-1500 form (or its electronic equivalent) is how we communicate with our local Part B Medicare Administrative Contractor the services we have performed and why we performed them.
- You are talking to a computer and all that it knows is what you tell it through the numbers that you put on the 1500 Form.
- There are two code sets that are used to communicate information to the MAC.
 - ICD-9-CM codes.
 - ICD-9-CM stands for International Classification of Disease, 9th edition, Clinical Modification.
 - We covered diagnosis in another webinar.
 - CPT codes.
 - CPT® stands for Current Procedural Terminology®
 - The CPT® Code Set is owned by the American Medical Association.
 - This is why there is a delay in the implementation of the ICD-10 codes.
 - The ICD-10 codes are used both for diagnosis and procedures coding.
- The new CMS 1500 form can be used now.
- It will be required after April 1 of this year.
- The CMS 1500 form is commonly called the 1500 form.
- It is printed in red because it is read by an Optical Character Recognition (OCR) scanner
- Electronic Health records require the same information that the 1500 form does.
- The top part of the form is for the patient information and the insured's information (if it is different from the patient's).
- The bottom part of the form is for the claim information.
- This is where you submit the charges.
- In the old form, Item 8 asked for marital and employment status.
- In the new form, Item 8 is now blank and we leave it blank.
- The old Item 9 looked like this.

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			
a. OTHER INSURED'S POLICY OR GROUP NUMBER			
b. OTHER INSURED'S DATE OF BIRTH			
MM	DD	YY	SEX
			M <input type="checkbox"/> F <input type="checkbox"/>
c. EMPLOYER'S NAME OR SCHOOL NAME			
d. INSURANCE PLAN NAME OR PROGRAM NAME			

- The new Item 9 looks like this.

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
a. OTHER INSURED'S POLICY OR GROUP NUMBER
b. RESERVED FOR NUCC USE
c. RESERVED FOR NUCC USE
d. INSURANCE PLAN NAME OR PROGRAM NAME

- Enter the last name, first name, and middle initial of the enrollee in a Medigap policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave blank.
- NOTE: Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the beneficiary wishes to assign his/her benefits under a MEDIGAP policy to the participating physician or supplier.
- Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for all Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.
- Medigap - Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute.
- It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare.
- It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage. Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.
- Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the carrier to send Medicare claim information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim.
- **Item 9a** - Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.
- NOTE: Item 9d must be completed, even when the provider enters a policy and/or group number in item 9a.

- **Item 9b** – Leave Blank
- **Item 9c** - Leave blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer.
- **Item 9d** - Enter the Coordination of Benefits Agreement (COBA) Medigap –based Identifier (ID).
- **Item 14** - Enter either an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date.
- Although this version of the form includes space for a qualifier, Medicare does not use this information; do not enter a qualifier in item 14.

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

- For chiropractic services, enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date of the initiation of the course of treatment and enter an 8-digit (MM | DD | CCYY) or 6-digit (MM | DD | YY) date in item 19.
- Reminder: For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). **Intermixing the two formats on the claim is not allowed.**
- Item 17 - Enter the name of the referring, ordering, or supervising physician if the service or item was ordered or referred by a physician.

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	
		17b.	NPI

- There are new qualifiers for physicians in box 17.
 - DN = Referring
 - DK = Ordering
 - DQ = Supervising
- All physicians who order services or refer Medicare beneficiaries must report this data.
- When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.
- The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:
 5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation).
- **Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.
- **Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

- Chiropractors can only order or refer for services directly related to manual manipulation to the spine to correct subluxation.
- For all other services you must send the patient back to their MD or DO for evaluation.
- **Referral:** Turning the patient’s care over to another doctor.
- **Request for Consult:** Requesting another doctor evaluate the patient and render an opinion and return the patient to you for continued care.
- **Item 17a** – Leave blank.
- **Item 17b** Form CMS-1500 – Enter the NPI of the referring, ordering or supervising physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.
- **Item 21** - Enter the patient's diagnosis /condition. All physician and nonphysician specialties (i.e., PA, NP, CNS, CRNA) use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnoses in priority order.

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

- The “ICD Indicator” identifies the ICD code set being reported. Enter the applicable ICD indicator according to the following:
 - 9 = ICD – 9 – CM
 - 0 = ICD – 10 – CM
- Do not report both ICD-9 and ICD-10 on the same form.
- Item 24 - The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service.
- **Item 24E** - Enter the diagnosis code reference letter as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis.
- The back of the CMS 1500 form has not changed.
- It contains notices to the physician and to the patient.
- When you sign the CMS 1500 form, this is still what you are agreeing to.
- SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
- (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
- This is how doctors fall prey to the False Claims Act.
- When you file a claim with the AT modifier and your records do not substantiate medical necessity, you have made a false statement to a government agency.
- Completing the CMS 1500 form is key to getting paid, but it also requires attention to detail to avoid reviews and other difficulties.