



## **CMS-1500 Health Insurance Claim Form Changes & ICD-10 Testing**

There is a new 1500 form that must be used for “Paper” billing as of April 1, 2014. The old (version 08/05) and the new forms (version 2/12) can both be used January 6, 2014 thru March 31, 2014. However, on April 1, 2014, payers who receive paper claims may only process claims that are submitted on the new version (2/12) CMS-1500 form. Version numbers can be found at the bottom right hand corner of the form.

Changes to the CMS-1500 form have been implemented to give providers the ability to indicate whether they are using ICD-9-CM codes or its counterpart, the ICD-10-CM, in preparation for the implementation of the ICD-10-CM codes on October 1, 2014. This change will also support ICD-10-PCS for Institutional billing.

The SolAce product supports both ICD-9-CM and the ICD-10 code sets and appropriate edits are in place to ensure that these codes are used at the proper times once the ICD-10 live date of October 1, 2014 comes around.

Although SolAce is not used for paper billing, the first screen on our Claim Editor page displays an image of the CMS-1500 form so users can print or save images of their claims for record keeping purposes. The notable changes users will notice on the new form and how the data will be displayed in the different tabs of the SolAce Claim Editor screen are described below.

### Notable Changes:

- **Box 8, Box 9b, Box9c** - Patient Status, Other insured date of birth and sex, and Employer’s Name or School does not exist in 837P 5010A1 so these have been removed from the form.
- **Box 10d**- Renamed Claim Codes and is used for Condition Codes. This field is not editable on this form to keep the correct formatting, but Condition Codes can be added on the Diagnosis Tab in the Claim Editor screen and will then view/print out in this box with the correct format.
- **Box 11b**- Renamed to Other Claim ID. This box is used for a Property Casualty Claim Number with a Y4 Qualifier.
- **Box 14** – Added a 3 digit qualifier field to show if this date is either Onset of Current Symptoms or Illness (431) or Last Menstrual Period (484). The user can store both dates here during data entry by selecting the correct qualifier and entering the date. The dates will be stored on the Diagnosis Tab of the Claim Editor screen and sent in the 837P. The date printed will be based on the selected qualifier on the form. (NOTE: If you are reporting an Accident Date, see Box 15 below)
- **Box 15**- Renamed to Other Date with qualifier field. This box has the same data entry logic as Box 14. Other Date options are:
  - Initial Treatment(454)
  - Latest Visit or Consultation(304) –Last Seen Date
  - Acute Manifestation of a Chronic Condition(453) – Acute Date shown on the Chiropractic Tab of the Claim Editor screen
  - Accident(439)
  - Last X-ray(455)
  - Prescription(471) – Under Vision heading on the Diagnosis Tab of the Claim Editor screen

- Report Start/Assumed Care Date(090) – Under Care Plan Oversight within the Provider Tab’s Service Facility Location section of the Claim Editor screen
- Report End/Relinquished Care Date(091) - Under Care Plan Oversight within the Provider Tab’s Service Facility Location section of the Claim Editor screen
- First Visit or Consultation(444) – Initial Treatment Date
- **Box 17**- Added qualifier field for Referring (DN), Ordering (DK), or Supervising (DQ) providers. All three types of the providers chosen here can be stored on the Provider Tab of the Claim Editor screen. The provider printed will be based on the selected qualifier.
- **Box 21**
  - Added ICD Ind field – 9 (ICD9 codes) or 0 (ICD-10 codes). Edit Checks will calculate which code to use based on codes entered if empty.
  - Added 8 additional lines for diagnosis codes. Codes Labeled A-L
- **Box 24E** – Diagnosis Ref Pointers are now A-L. Note that in the 837P, the Diagnosis Ref Pointers are 1-12, but SolAce takes care of this conversion in translation. If 1-4 are still used on the form Edit Checks will convert to letters.
- **Box 30**- Removed Balance Due since it is not used in 837P 5010A1

**Note to users that import files into SolAce:**

- 837P import files: SolAce will import your files as is and translate the data into the proper fields of the new form. It will change your diagnosis pointers from the numerical values to the alphabetical values.
- Print Image import files:
  - Print Image on old format: SolAce will import your files as is and translate the data into the proper fields of the new form. It will change your diagnosis pointers from the numerical values to the alphabetical values.
  - Print Image on new format : If you find your import is off once you have updated your Print Image’s format, please give us a call so your SolAce map can be adjusted.
  - CSV import files: SolAce will import your files as is and translate the data into the proper fields of the new form. It will change your diagnosis pointers from the numerical values to the alphabetical values. If you changed your CSV column headers and find that your import is off, please give us a call so we can adjust your CSV map.

**SolAce will be updated with the above changes on Sunday, March 2, 2014**

**ICD-10 Testing Information:**

Most receivers are making ICD-10 testing OPTIONAL due to the fact that testing will only verify if your ICD-10 codes are generating correctly on your 837 EDI files. It will not be tested for proper coding based on your line of business. There are only a FEW receivers who are making ICD-10 testing mandatory (smaller commercial payers) and those receivers will strongly communicate their testing guidelines directly to the submitters (YOU) via email, so please make sure you read all of the emails that are sent to you by your payers regarding ICD-10 testing. If you have a receiver that is implementing mandatory ICD-10 testing, please forward the testing information they have shared with you to us at [support@solace-emc.com](mailto:support@solace-emc.com) so we can assist you with your testing.

If you do decide to participate in the Optional Testing for ICD-10, you will need to make sure that you prepare a claim using the ICD-10-CM codes. Once you have a claim ready, give us a call at 602-439-2525 and we will assist you in ensuring your file is generated as a TEST file and that it is sent to the proper TEST system that your receiver is using for ICD-10 test files. Please be aware that receivers have different Testing dates for ICD-10. You will need to contact your receiver’s EDI helpdesk directly to inquire about their ICD-10 test dates.

# CMS-1500 Version 2/12 Sample

Highlights = Areas that changed

HEALTH INSURANCE CLAIM FORM											
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12											
<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK (LUNG) <input type="checkbox"/> OTHER <small>(Medicare#) (Medicaid#) (Do#Do#) (Member ID#) (ID#) (ID#)</small>										FIGA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
1. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER <small>(For Program in Item 1)</small>	
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
CITY			STATE			8. RESERVED FOR NUCC USE			CITY		
ZIP CODE			TELEPHONE (Include Area Code) ( ) ( )			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO:		
10a. OTHER INSURED'S POLICY OR GROUP NUMBER			10b. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			10c. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			10d. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
10e. INSURANCE PLAN NAME OR PROGRAM NAME			10f. CLAIM CODES (Designated by NUCC)			11. INSURED'S POLICY GROUP OR FECA NUMBER			11a. INSURED'S DATE OF BIRTH MM DD YY		
11b. OTHER CLAIM ID (Designated by NUCC)			11c. INSURANCE PLAN NAME OR PROGRAM NAME			11d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <small>If yes, complete items 9, 9a, and 9c</small>			12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE			DATE			13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.			SIGNED		
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (MM/ DD/ YY)				15. OTHER DATE (MM/ DD/ YY)				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM/ DD/ YY TO MM/ DD/ YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. QUAL				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM/ DD/ YY TO MM/ DD/ YY			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO				20. \$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Retain A-I to service line below (24E)				ICD-9cm				22. RESUBMISSION CODE ORIGINAL REF. NO.			
24. A. DATE(S) OF SERVICE From MM/ DD/ YY To MM/ DD/ YY				B. PLACE OF SERVICE EMG				C. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			
D. DIAGNOSIS POINTER				E. \$ CHARGES				F. G. DAYS OR UNITS			
H. EFFECT PERCENT (%)				I. QUAL				J. RENDERING PROVIDER ID #			
25. FEDERAL TAX I.D. NUMBER				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
28. TOTAL CHARGE \$				29. AMOUNT PAID \$				30. Revd for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ( )			
SIGNED				DATE				PLEASE PRINT OR TYPE			

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org) APPROVED OMB-0938-1107 FORM 1500 (02-12)