Part B Insider (Multispecialty) Coding Alert

Medicare Forms: New CMS-1500 Aims to MakeDiagnosis Coding Easier

Be ready to start using the redesigned paper form as of January 1.

It's not every day that your practice has to drop a claim to paper to file with Medicare. In most cases, you file electronically, which CMS far prefers. But in some situations, filing a paper claim is an unavoidable necessity, and CMS is about to change how you do that.

Effective Jan. 6, 2014, you'll be able to start using the redesigned CMS-1500 form (version 02/12), which includes indicators for differentiating between ICD-9 and ICD-10, expands the number of diagnosis codes to 12, and includes qualifiers so you can identify ordering, referring, and supervising providers. Although MACs will start accepting the form on Jan. 6, you won't be required to start using it until April 1.

"The fact that the previous form only allowed four diagnosis codes was a problem for a lot of practices, since it's easy to list six or seven ICD-9 codes for a simple fall off a ladder, once you include E codes and V codes," says **Terry Karesh,** billing manager for six medical practices in Philadelphia. "In the past, if you had more than five diagnosis codes, you had to submit electronically, which isn't feasible for every situation or some payers allowed you to squeeze two ICD-9 codes in the same field separated by a comma, which could easily get misread by the payer."

When Can You Bill Paper Claims?

But don't get so excited over the new CMS-1500 form that you start filling out all of your claims with it. As most Part B practices are aware, you are required to submit Medicare claims electronically in the HIPAA format "except in limited situations," CMS advises in its Medicare Claim Submissions Guidelines brochure. If you meet one of those scenarios, you are typically allowed to submit your claims on paper. The situations in which you're permitted to submit a paper claim include the following:

- Small provider claims. If you have fewer than 25 full-time employees and you're required to bill a Medicare intermediary, you're considered small, whereas if you bill a Medicare carrier or DME carrier, you must have fewer than 10 full-time employees to be considered small.
- Roster billing of inoculations covered by Medicare, unless you agree to submit these claims electronically as a condition for submitting flu shots administered in multiple states to a single carrier.
- Claims under a Medicare demonstration project that specifies you can submit via paper.
- Medicare Secondary Payer claims when more than one primary payer is involved and one or more of those payers made an "Obligated to accept as payment in full (OTAF) adjustment"
- Claims submitted directly by Medicare beneficiaries or Medicare Managed Care plans
- Dental claims
- Claims for services or supplies furnished outside of the U.S. by non-U.S. providers
- Disruption in electricity or communication connections outside of a provider's control expected to last more than two business days
- Claims from providers that submit fewer than 10 claims per month on average per calendar year.

Ensure that you meet one or more of the above criteria before submitting a paper claim to avoid any penalties associated with failing to file an electronic claim.

To read more about when you're allowed to bill paper claims, visit

www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/ASCASelfAssessment.html. For more on the new CMS-1500 form, visit www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Downloads/2013-06-27Enews.pdf.