Supporting Statement for Proper Claim Not Filed
and Supporting Regulation Contained in
42 CFR 411.32(c)

A. Background

The Centers for Medicare & Medicaid Services (CMS), is seeking approval of the information collection requirements to continue to collect information from beneficiaries, providers, physicians, or suppliers on health insurance coverage that is primary to Medicare.

Medicare Secondary Payment (MSP) is essentially the same concept as coordination of benefits in the private insurance industry. It refers to those situations where Medicare does not have primary responsibility for paying the medical expenses of a Medicare beneficiary.

B. Justification

1. Need and Legal Basis

42 U.S.C. 1395y(b) is the statutory basis for MSP provisions. 42 CFR 411.32(c) is the section that requires a provider, supplier, or beneficiary to notify Medicare that a claim to a third party was improperly filed and that payment was reduced as a result .

2. Information Users

Medicare Part A and Part B and DME Contractors use this information to determine the proper Medicare secondary payment .

3. Improved Information Technology

The data, when submitted by physicians, providers and other suppliers, is almost always submitted electronically with Medicare claims. There is not enough need to enable beneficiaries to submit the information electronically, nor do most of them have electronic means to convey the information. The circumstances when Medicare beneficiaries submit claims directly to Medicare Part A and Part B contractors are extremely limited.

4. Duplication of Similar Information

None.

5. Small Businesses

The information collection is as minimal as possible; the submission of the data is part of submitting a claim to Medicare and does not add any burden.

6. Less Frequent Collection

The information is submitted only once per improperly submitted claim; it cannot be submitted less frequently and comply with regulations.

7. Special Circumstances
None.

8. Federal Register Notice/Outside Consultation
The 60-day Federal Register notice published on July 7, 2006.

9. Payment/Gift To Respondent
None.

10. Confidentiality
All claims information is protected by the Privacy Act.

11. Sensitive Questions
None.

12. Burden Estimate (Total Hours & Wages)
Section 411.32(c) requires physicians, providers, other suppliers, and beneficiaries, in case where they failed to submit a proper claim with a third party payer to report these situations on the current Medicare forms. The primary payer will notify the physician, provider, other supplier, or beneficiary of the amount normally payable, the amount of the reduction payable because the claim was not filed properly, and the amount the physician, provider, other supplier, or beneficiary is being paid under the "primary plan" due to the reduction. The information is transmitted on an explanation of benefits or remittance advice determination that third party payers provide to all covered individuals and physicians, providers and other suppliers as part of an industry practice. The information contained in this explanation, whether or not it concerns improperly filed claims, is submitted to Medicare as part of the claims process.

We estimate that perhaps 0.1 percent of all Medicare claims, or 1,129,000 out of 1,129,000,000 of all claims processed, are subject to this requirement. **However, there is no burden associated with this collection that is separate from the burden associated with filing a claim for Medicare reimbursement. With that being the case, we are submitting the following data to OMB.**

1,129,000 respondents
1,129,000 responses
1 token hour

Due to the limitation of the new ICRAS system, the information will appear as 2 respondents, 2 responses, and 2 burden hours requested.

PRA BURDEN ATTRIBUTABLE TO 42CFR 411.32(c)

Background: 42CFR 411.32 is titled “Basis for Medicare secondary payments.” Part c is titled “General limitation: Failure to file a proper claim.” The affected language in Part c states: “The provider, supplier, or beneficiary must inform CMS that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.” We have identified the CMS 1450 and the CMS 1500 claim forms, with attachments, as the only tools used to collect this information.

Methodology:

Part A claims: CMS 2005 Statistics shows that Medicare processed approximately 179,000,000 Part A claims. Approximately only .001 are estimated to be Medicare Secondary Payer claims where the provider or beneficiary informed CMS that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed. The 1450 claim form contains three (3) form locators for value codes. There are eighty-six (86) form locators in total on the 1450 claim form. Note that the total hour burden associated with completing the 86 form locators on the 1450 claim form for all Medicare claims in FY2005 is 1,997,581 hours.

Therefore, to estimate the burden, we multiply .001 percent times 179,000,000 total claims times the three seconds it takes to fill our form locators 39-41 with the primary payer payment amount information divided by 60 to identify the minutes, divided by 60, again, to identify the hours of burden (179,000,000 times .001 times 3 seconds divided by 60 divided by 60 = 149 hours to identify the primary payment amount in FL 39-41).

Part B claims: CMS 2005 Statistics shows that Medicare processed approximately 950,000,000 Part B claims. Approximately only .001 we estimated to be Medicare Secondary Payer claims where the physician, other supplier, or beneficiary informed CMS that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed. There are thirty-three (33) item fields on the CMS 1500 for which only one item, number 26, identifies the primary payer amount. The physician, other supplier or beneficiary attaches the explanation of benefits (EOB) or remittance advice (RA) to the CMS 1500, as necessary, which contains the other primary payer amounts needed to process the claim. Note that the total hour burden associated with completing all 33 items on the CMS-1500 claim form for all Medicare claims in FY2005 is 46,383,364 hours.

Therefore, to estimate the burden, we multiply .001 percent times 950,000,000 total claims times the three seconds it takes to fill out item 26 and to attach the EOB or RA with the additional primary payer payment amount information divided by 60 to identify the minutes, divided by 60, again, to identify the hours of burden (950,000,000 times .001 times 3 seconds divided by 60 divided by 60 = 792 hours).

13. Capital Costs (Maintenance of Capital Costs)
None.

14. Cost to Federal Government
None.

15. Program or Burden Changes

There is a program change in the sense that this information collection requirement of the regulations section is again subject to the Paperwork Reduction Act of 1995. Since 2003 we have claimed no burden in that this collection is not subject to the PRA because it is an administrative action. Also, the other sections and their hourly burdens once in this collection are contained in other collections (0938-0214) or they were mistakenly identified as information collection requirements.

For our last approval for section 432.32(c), we estimated 5,449 hours to comply with the requirement if this activity were to be viewed in isolation. However, as explained above, there is no actual burden.

16. Publication and Tabulation Dates
None.

17. Expiration Date
The expiration dates, to the extent applicable, will be on the claims forms to which this regulations section will apply. There is no form specific to this requirement on which to put an expiration date.

18. Certification Statement
There are no exceptions.

C. Collection of Information Employing Statistical Methods
Not applicable.