Supporting Statement for the CMS-1500 (08-05)[1] (Health Insurance Claim Form)
And Supporting Regulations in 42 CFR Part 424 Subpart C
March 2007

A. Background

The Form CMS-1500 answers the needs of many health insurers. It is the basic form prescribed by CMS for the Medicare program for claims from physicians and suppliers. The Medicaid State Agencies, CHAMPUS/TriCare, Blue Cross/Blue Shield Plans, the Federal Employees Health Benefit Plan, and several private health plans also use it; it is the de facto standard "professional" claim form.

The National Uniform Claim Committee (NUCC) currently governs form CMS-1500. Within the NUCC, the form is assigned to the CMS-1500 Subcommittee, which is responsible for maintaining the form. The NUCC completed modifications to the form in June 2006 mainly for the purpose of accommodating the National Provider Identifier, which is mandated to be used May 23, 2007 (small health plans are required to implement May 23, 2008). This new version (08/05) was given a one year approval by the Office of Management and Budget and is now being submitted for renewal for three years.

B. Justification

1. Need and Legal Basis

Section 1861(s) of the Social Security Act lists the services covered by the Supplementary Medical Insurance Program (SMI). The CMS-1500 is used to bill for services covered under section 1861(a)(1) by persons entitled to payment for such services in accordance with section 1832(a)(1) of the Social Security Act. Benefits are paid either to the physician/supplier under an agreement, the beneficiary on the basis of an itemized bill per section 1842(b)(3)(B)(i) and (ii) of the Social Security Act, or to an organization authorized to receive payment per 1842(b)(6).

42 CFR 424 Subpart C sets out the procedures and policies for implementing section 1861(s), 1832(a)(1), 1833, and 1842(b)(3)(B)(i) and (ii). These procedures require that for payment to be made to the beneficiary, a written request for payment must be submitted together with an itemized bill. For payment to the person who provided the services, the provider must accept assignment, agree to accept the reasonable charge for the services as the full charge and agree not to charge the beneficiary for more than any unpaid deductible and the 20 percent coinsurance.

Per 42 CFR 424.44(a), the request for payment must be submitted no later than the close of the calendar year following the year in which the services were furnished.

[1] With the agency name change from Health Care Financing Administration (CMS) to Centers for Medicare & Medicaid Services (CMS), all form numbers that had been preceded by "HCFA" are now preceded by "CMS."

CMS, in order to ensure that proper payment is made for any medical and other health services listed under section 1861(s) of the Social Security Act, needs to elicit a description of the services and the charges from the individual beneficiary or from the physician or supplier for the Medicare carrier. The CMS-1500 and CMS-1490S meets this need.

2. Information Users

Medicare carriers use the data collected on the CMS-1500 and the CMS-1490S to determine the proper amount of reimbursement for Part B medical and other health services (as listed in section 1861(s) of the Social Security Act) provided by physicians and suppliers to beneficiaries. The CMS-1500 is submitted by physicians/suppliers for all Part B Medicare. Serving as a common claim form, the CMS-1500 can be used by other third-party payers (commercial and nonprofit health insurers) and other Federal programs (e.g., CHAMPUS/TriCare, RRB, and Medicaid).

The advantage of a common claim form is that physicians and suppliers no longer need to stock a variety of forms and thus are able to increase their office efficiency through continual utilization of the same form. Specific instructions for completion of the form are contained in the Medicare Carriers Manual. Periodically, the Medicare carriers furnish informational materials to the physicians and suppliers as to how to complete the form.

However, as the CMS-1500 displays data items required for other third-party payers in addition to Medicare, the form is considered too complex for use by beneficiaries when they file their own claims. Therefore, the CMS-1490S (Patient's Request for Medicare Payment) was explicitly developed for easy use by beneficiaries who file their own claims. The form can be obtained from any Social Security office or Medicare carrier.

However, when the CMS-1490S is used, the beneficiary must attach to it his/her bills from physicians or suppliers. The form is, therefore, designed specifically to aid beneficiaries who cannot get assistance from their physicians or suppliers for completing claim forms.

Since the last renewal, CMS obsoleted the CMS-1490U which was used by employers, unions, employer-employee organizations that pay physicians and suppliers for their services to employees, group practice prepayment plans, and health maintenance organizations. Therefore, this collection will no longer contain the CMS-1490U.

In sum, the CMS-1500 and CMS-1490S result in less paperwork burden placed on the public. The CMS-1500 provides efficiency in office procedures for physicians and suppliers; the CMS-1490S provides beneficiaries with a relatively easy form to use when filing their claims. Without the collection of this information, claims for

reimbursement relating to the provision of Part B medical services/supplies could not be acted upon. This would result in a nationwide paralysis of the operation of the Federal Government's Part B Medicare program, and major problems for the other health plans that use the CMS-1500, inflicting severe physical and financial hardship on providers/suppliers as well as beneficiaries.

3. Improved Information Technology

These forms are continually reviewed for potential burden reduction through improved technology. We have standardized the format of the CMS-1500 so that all payers (not just Medicare) can uniformly receive and process claims. We have designed the CMS-1500 to be scannable for those payers that have optical character recognition capabilities. Scanning allows them to significantly reduce their data entry and other administrative costs.

Electronic data interchange is a technology alternative to the submission of paper claim forms. All of the data collected by the CMS-1500 can also be collected electronically. The electronic equivalent to the CMS-1500 form is the ANSI X12N 837 Professional claim (837P), which further reduces costs and increases efficiency for providers and suppliers. Recent legislation has also been enacted which mandate claims be submitted electronically to Medicare. The Administrative Simplification Compliance Act amendment to section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is received in a non-electronic form. Consequently, absent an applicable exception, paper claims received by Medicare will not be paid. Entities determined to be in violation of the statute or this rule may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

4. Duplication/Similar Information

There are no duplicative efforts to capture the information found on these forms.

5. Small Business

An earlier version of the CMS-1500 (HCFA-1500, 1/84) was developed in the early 1980's by an American Medical Association (AMA)-sponsored work group representing both private and government (including Medicare) insurers. The purpose of the current CMS-1500 is to accommodate a wide variety of users, thus maximizing advantages to the small business community by reducing the number of health insurance claim forms that must be purchased, stocked, prepared, and submitted to various insurers.

Moreover, this workgroup has continued its review of the CMS-1500 to minimize burden on the operation of small businesses. Physicians/suppliers are kept up to date regarding Medicare instructions on how to expeditiously complete the CMS-1500 by

way of newsletters, pamphlets, etc., issued by the Medicare carriers. There is no significant impact on small business.

6. Less Frequent Collection

In order for reimbursement to proceed in a timely and accurate manner, claims for reimbursement should be submitted soon after the provision of service. Consequently, there is no coherent or beneficial approach regarding the submitting of claims on a less frequent basis. Moreover, extended delays in the processing of Part B claims would increase the probability of errors while potentially imposing cash flow problems on physicians/suppliers as well as beneficiaries.

7. Special Circumstances

--*Requiring respondents to report information to the agency more often than quarterly.*

Physicians and suppliers submit claim forms "on occasion." In most circumstances, this is more often than quarterly. Submission of claim forms is necessary for reimbursement.

--*Including a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported in disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or requiring respondents to submit proprietary trade secret or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.*

Any information reported on these forms is protected and held confidential in accordance with 20 CFR 401.3. Refer to item 10 for additional information regarding confidentiality.

8. Federal Register Notice/Outside Consultation

A 60-day Federal Register Notice was published on April 27, 2007.

General collection guidelines:

This collection of information is conducted in a manner consistent with the guidelines in 5 CFR 1320.6.

Outside consultation:

The CMS-1500 was developed based upon consultation with the National Uniform Claim Committee. The task force is comprised of representatives from payer, provider, standards development organizations, and vendor organizations.

Most recently, the NUCC has made several slight modifications to the CMS-1500 form to accommodate the National Provider Identifier. As a result of consultation among the NUCC sub-committee members and their constituent organizations, the following changes were made and were reflected in the CMS-1500, 08/05.

a. Header, barcode in the header removed;
b. Header, "PLEASE DO NOT STAPLE IN THIS AREA" removed from the left-hand side;
c. Header, newly designed "1500 logo" added to the left-hand side of the header;
d. Header, title "HEALTH INSURANCE CLAIM FORM" moved from the upper, right-hand side to the upper left-hand side;
e. Header, language "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05" added to the left-hand side;
f. Boxes 1a, 7, 10, 21, & 24b, upper case lettering within parentheses changed to lower case;
g. Box 1, "TRICARE" added above "CHAMPUS";
h. Box 1, under CHAMPVA, "VA File #" changed to "Member ID#";
i. Box 17, title changed from "NAME OF REFERRING PHYSICIAN OR OTHER SOURCE" to "NAME OF REFERRING PROVIDER OR OTHER SOURCE";
j. Box 17a, split horizontally into box 17a and 17b which will accommodate the Other ID # and the NPI # of the referring or ordering provider;
k. Box 21, lines after the decimal point in items 1, 2, 3, and 4 extended to accommodate four bytes;
l. Box 24, line with the alpha indicators removed. The alpha indicators moved next to the respective titles in the title fields;
m. Box 24, detail line numbers to the left of Box 24 increased in size and centered with each line;
n. Box 24, each detail line split length-wise and shading added to the top portion of each line. This area is to be used for the reporting of supplemental information;
o. Box 24C, changed from "Type of Service" to "EMG";
p. Box 24D, expanded to capture 4 modifiers;
q. Box 24E, decreased by 3 bytes and the heading was changed from "Diagnosis Code" to "Diagnosis Pointer";
r. Box 24G, expanded to 3 bytes;
s. Box 24H, decreased to 1 byte;
t. Box 24I, title changed from "EMG" to "ID. QUAL."
u. Box 24J, title changed from "COB" to "RENDERING PROVIDER ID. #";
v. Boxes 24I and 24J, split horizontally to accommodate the Other ID # and the NPI # of the rendering provider. The top half of the field will accommodate legacy provider ID # and the NPI # will be on the bottom half of the field;
w. Box 24K, removed and relabeled as 24J;
x. Boxes 32a and 32b, added in box 32 to accommodate an NPI # (32a) and legacy provider ID # (32b);

y. Box 33, title “PHYSICIAN’S, SUPPLIER’S, BILLING NAME, ADDRESS, ZIP CODE, & PHONE #” changed to “BILLING PROVIDER INFO & PH #”;
z. Box 33, the “PIN #” box was changed to 33a for the NPI # and the “GRP #” box was changed to 33b for the legacy provider ID #;
aa. Footer, language “Approved by AMA Council on Medical Service 8/88” removed from the left-hand side;
bb. Footer, language “NUCC Instruction Manual available at: www.nucc.org” added to the left-hand side;
cc. Footer, language “Please Print or Type” removed from the center;
dd. Back, bottom of the form, the first line of the address changed from “CMS, N2-14-26” to “CMS, Attn: PRA Reports Clearance Officer”;
ee. Back, language added in the last line at the bottom of the form: “This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.”

9. Payment/Gift to Respondent

The CMS-1500 must be used to receive payment for the provision of health care services or supplies. The use of the form itself does not convey payments or gifts to respondents; many conditions must be met before payment can be made.

10. Confidentiality

The information provided on these forms is protected and held confidential in accordance with 20 CFR 401.3. The information provided on these forms will become part of the Medicare contractors’ computer history, microfilm, and hard copy records’ retention system as published in the Federal Register, Part VI, “Privacy Act of 1974 System of Records,” on September 20, 1976 (HI CAR 0175.04).

The following statement appears on the reverse of the CMS-1500: “No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).”

The following statement appears on the front of the CMS-1490S: “No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).”

The following statement appears on the front of the CMS-1490U: “No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 405.1678).”

The following statement required by the Privacy Act of 1974 (USE 55(a)(3)) is included on the reverse of the CMS-1500:

PRIVACY ACT STATEMENT

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act, as amended, 42 CFR 411.24(a) and 424.5(a)(6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third party payers to pay primary to a Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the “Computer Matching and Privacy Protection Act of 1988” permits the government to verify information by way of computer matches.

The following statement required by the Privacy Act of 1974 (USE 55(a)(3)) is included on the reverse of the CMS-1490S:

COLLECTION AND USE OF MEDICAL INFORMATION

We are authorized by the Health Care Financing Administration to ask you for information needed in the administration of the Medicare program. Authority to collect information is in section 205(a), 1872, and 1875 of the Social Security Act as amended. The information we obtain to complete your Medicare claim is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by Medicare and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information about the Medicare benefits you have used to a hospital or doctor.

With one exception, which is discussed below, there are no penalties under social security law for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of the claim. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work-related injury so we can determine whether workmen's compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information.

11. Sensitive Questions

This data collection does not ask questions of a sensitive nature, such as sexual behavior or religious beliefs.

12. Burden Estimate (Wages and Hours)

The figures used to compute the annual burden represent the number of professional claims processed in CY 2006. During CY 2006, 92.5 percent of the professional Medicare claims were received electronically.

	Number of Claims	Burden/Claim	Total Burden
Paper	72,420,796	15 minutes	18,105,199 hrs.
Electronic	897,753,464	1 minute	14,962,558 hrs.
TOTALS	970,174,260	N/A	33,067,757 hrs.

We estimate the cost per hour of burden to average $15.00 per hour. This estimate takes into account labor and resource cost.

Medicare does not furnish forms to physicians and suppliers. Physicians and suppliers must purchase the forms. The CMS-1500 form costs on average $0.06 per claim (two-part form). Medicare does not reimburse providers for their mailing and handling costs. This costs physicians and suppliers between $.39-.60/claim (or an average of $ .50/claim).

In order to save costs to the program, Medicare provides free electronic billing software and support for the electronic equivalent of the CMS-1500. This free electronic billing software saves time and money for physicians and suppliers, as well as lowers Medicare's administrative claims processing costs.

Labor Costs

33,067,757 hours X $15 = $496,016,355

In addition, physicians and suppliers spend approximately $0.56/claim in resource cost (this figure includes both form costs and mailing). Therefore, based on these numbers, physicians and suppliers spend approximately:

Cost of Forms and Mailing of Forms

Number of Claims	Cost/Claim for	Total Annual Cost

		Forms and Mailing	for Forms and Mailing
Paper	72,420,796	*($.56)	$ 40,555,645
Electronic	897,753,464	**N/A	$ 71,820,277
Total	970,174,260	N/A	$112,375,922

* This figure was attained by adding $.06/claim cost to an average mailing cost of $ .50.
** This figure was attained by using this formula:
897,753,464 electronic claims X $ .08 (phone line charge) = $ 71,820,277)

Variables:
Transmission (line) Costs: $ .08/claim
Total professional electronic claims: 897,753,464

Total Costs:

Labor costs:	$496,016,355
+ Cost of forms and mailing of forms:	$112,375,922
= Total costs:	$608,392,277
Current costs:	$608,392,277
- Previous costs:	$831,013,172
= Difference	$-222,620,895

This represents a cost decrease of $222,620,895 from the previous reporting period.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

Based on FY 2005 figures, the administrative cost to the Federal Government to administer Medicare Part B (for which the professional claim is used to report services and obtain reimbursement) was $2,914,000,000 or 1.9 percent of benefit payments.[2] On the average, the unit cost incurred to the Federal Government per professional claim was $ .52[3] in FY 2005. This figure includes the direct costs and overhead cost for claims payment, reviews and hearings, and beneficiary/physician inquiry lines.

15. Program Changes/Burden Changes

[2] Source: 2006 CMS Statistics, Table 47.
[3] Source: 2006 CMS Statistics, Table 51.

The reported decrease in the costs from the previous reporting period is due mainly to the enforcement of mandatory electronic claim submission requirements which are part of the Administrative Simplification Compliance Act. Administrative Simplification Compliance Act (ASCA). Section 3 of the ASCA, PL107-105, and the implementing regulation at 42 CFR 424.32, requires providers, with limited exceptions, to submit all initial claims for reimbursement under Medicare electronically, on or after October 16, 2003. Further, ASCA amendment to Section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Consequently, unless a provider fits one of the approved exceptions, any paper claims submitted to Medicare will not be paid**.** ASCA is responsible for the significant increase in the number of claims being filed electronically as well as the significant decrease in the total receipts of paper claims.

16. Publication and Tabulation Dates

The purpose of this data collection is to pay providers for Medicare services rendered and to reimburse beneficiaries when applicable. There are no publication and tabulation dates.

17. Expiration Date

Previous forms have been cleared without the expiration date present. Placing the expiration date on the form would require form changes. This would result in additional printing costs to CMS, and confusion among providers and/or beneficiaries.

18. Certification Statement

CMS has no exceptions to Item 19, "Certification for Paperwork Reduction Act Submissions," of OMB Form 83-I.

C. Statistical Methods

These information collection requirements do not employ statistical methods.