Supporting Statement for the CMS-1500 (02-12) (Health Insurance Claim Form) And Supporting Regulations in 42 CFR Part 424 Subpart C and CMS-1490S (01/05) April 2012

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, 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.

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. 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 Administrative Contractor. The CMS-1500 and CMS-1490S meets this need.

2. Information Users

Medicare Administrative Contractors 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., 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 Internet Only Manual, Pub 100-04, Chapter 26. Periodically, the Medicare Administrative Contractors furnish informational materials to the physicians and suppliers as to how to complete the form.

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 CMS-1490S form can be obtained from any Social Security office or Medicare Administrative Contractors.

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.

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. The format of the CMS-1500 has been standardized so that all payers (not just Medicare) can uniformly receive and process claims. The CMS-1500 has been designed to be scannable by those payers that have imaging and 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. Legislation has also been enacted which mandates 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

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 May 29, 2012.

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 Uniform Claim Task Force members. The task force was co-chaired by the AMA and CMS (then HCFA). The task force was comprised of representatives of the Blue Cross/Blue Shield Association, CHAMPUS, the Department of Labor, the Health Insurance Association of America, the Railroad Retirement Board, and the National Association of State Medicaid Directors. This task force was replaced by the National Uniform Claim Committee (NUCC).

Most recently, the NUCC has revised the CMS-1500. The NUCC began revision work on the 1500 Claim Form, version 02/12 in 2009. The goal of this work was to align the paper form with some of the changes in the electronic Health Care Claim: Professional (837), 005010X222 Technical Report Type 3 (5010) and 005010X222A1 Technical Report Type 3 (5010A1). During the revision work, consideration was given to different approaches to revising the form. The NUCC decided to proceed with making "minor changes" to the current form, which was defined as no physical changes to the existing form lines or underlying layout of the form. The following changes were made and were reflected in the CMS-1500, 02/12

a. Header, Replaced 1500 rectangular symbol with black and white two-dimensional Quick Response Code (QR Code);
b. Header, Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE";
c. Header, Replaced "08/05" with "02/12";
d. Box 1, Deleted "CHAMPUS" and changed "(Sponsor's SSN)" to "(ID#/DoD#)";
e. Box 1, Under "GROUP HEALTH PLAN," changed "(SSN or ID)" to "(ID#)";
f. Box 1, Under "FECA BLK LUNG," changed "(SSN)" to "(ID#)";

g. Box 1, Under "OTHER," changed "(ID)" to "(ID#)";
h. Box 8, Deleted "PATIENT STATUS" and content of field. Changed title to "RESERVED FOR NUCC USE";
i. Box 9b, Deleted "OTHER INSURED'S DATE OF BIRTH, SEX." Changed title to "RESERVED FOR NUCC USE";
j. Box 9c, Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "RESERVED FOR NUCC USE";
k. Box 10d, Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)";
l. Box 11b, Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "OTHER CLAIM ID (Designated by NUCC)." Added vertical, dotted line in the left-hand side of the field to accommodate a 2-byte qualifier;
m. Box 11d, Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d";
n. Box 14, Changed title to "DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)". Removed the arrow and text in the right-hand side of the field. Added "QUAL" and a vertical, dotted line to accommodate a 3-byte qualifier;
o. Box 15, Changed title from "IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE" Added "QUAL" with two dotted lines to accommodate a 3-byte qualifier;
p. Box 17, Added a vertical, dotted line in the left-hand side of the field to accommodate a 2-byte qualifier;
q. Box 19, Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)";
r. Box 21, Added "ICD Ind." and two vertical, dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator;
s. Box 21, Added 8 additional lines for diagnosis codes. Evenly spaced the diagnosis code lines within the field;
t. Box 21, Changed labels of the diagnosis code lines to alpha characters (A – L);
u. Box 21, Removed the period within the diagnosis code lines;
v. Box 22, Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION";
w. Box 24E, Captures letters as diagnosis pointers instead of numbers;
x. Footer, language, Removed OMB approval numbers and added "OMB APPROVAL PENDING." OMB approval number will be added after approval has been granted;
y. Back, language **REFERS TO GOVERNMENT PROGRAMS ONLY** replaced with "MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR

411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11";

z. Back, language **SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)** replaced with "In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or CHAMPUS; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.

   For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

   For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

   No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

aa. Back, language **Privacy Act Statement** revised to "We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, 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 parties payers to pay primary to 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.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in

connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

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.

bb. Back, language **PRA disclosure statement** replaced with "According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-XXXX** . The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. 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 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 CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, 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 parties payers to pay primary to 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.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private

collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

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 MEDICARE INFORMATION

We are authorized by the Centers for Medicare & Medicaid Services 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 about the Medicare benefits you have used.

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)

CMS 1500

The figures used to compute the annual burden represent the number of professional claims processed in CY 2011. During CY 2011, 97.9 percent of the professional Medicare claims were received electronically. Medicare's Office of Financial Management records for CY2011 indicate that 1,448,346 providers/suppliers were enrolled in Medicare Part B.

	Number of Claims	Burden/Claim	Total Burden
Paper	21,221,080	15 minutes	5,305,270 hrs.
Electronic	966,783,965	1 minute	16,113,066 hrs.
TOTALS	988,005,045	N/A	21,418,336 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 $0.08 per claim (two-part form). Medicare does not reimburse providers for their mailing and handling costs. This costs physicians and suppliers between $.45-.65/claim (or an average of $ .55/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

21,418,336 hours X $15 = $321,275,040

In addition, physicians and suppliers spend approximately $0.63/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 Forms and Mailing	Total Annual Cost for Forms and Mailing
Paper	21,221,080	*($.63)	$ 13,369,280
Electronic	966,783,965	**N/A	$ 77,342,717
Total	988,005,045	N/A	$ 90,711,997

* This figure was attained by adding $.08/claim cost to an average mailing cost of $ .55.
** This figure was attained by using this formula:
966,783,965 electronic claims X $ .08 (phone line charge) = $ 77,342,717

Variables:
Transmission (line) Costs: $ .08/claim
Total professional electronic claims: 966,783,965

Total Costs:

Labor costs:	$321,275,040
+ Cost of forms and mailing of forms:	$ 90,711,997
= Total costs:	$411,987,037

Current costs:	$411,987,037
- Previous costs:	$452,786,074
= Difference	$- 40,799,037

This represents a cost decrease of $40,799,037 from the previous reporting period.

CMS 1490S

The count of CMS-1490S paper forms is included in the 21,221,080 total and is therefore reflected in the burden figures above.

13. Capital Costs

There are no capital costs.

14. Cost to Federal Government

Based on FY 2010 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 $3,514,000,000 or 1.3 percent of benefit payments.[1] On the average, the unit cost incurred to the Federal Government per professional claim was $ .38[2] in FY 2008. 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

The reported decrease in the costs from the previous reporting period is once again due in large part to the enforcement of mandatory electronic claim submission

[1] Source: 2011 CMS Statistics, Table V.1.
[2] Source: 2009 CMS Statistics, Table V.5. (Data not available in 2011 CMS Statistics Table V.5)

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, A Certification for Paperwork Reduction Act Submissions,≅ of OMB Form 83-I.

C. Statistical Methods

These information collection requirements do not employ statistical methods.