

## Supporting Statement - Part A

### Health Insurance Common Claims Form and Supporting Regulations at 42 CFR Part 424, Subpart C (CMS-1500 (02-12) and 1490S (version 01/18); OMB-0938-1197)

#### 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.

The 1490S form was designed to specifically aid beneficiaries who cannot get assistance from their physicians or suppliers for completing claim forms. The beneficiary must attach his/her bills from physicians or suppliers to the 1490S form prior to submitting the claim form to Medicare.

CMS is requesting an extension approval with no changes from OMB of this previously approved PRA package.

#### B. Justification

##### 1. Need and Legal Basis

Social Security ACT, Part E, Section 1861(s) provides definition of services and institutions covered under the Act. The CMS-1500 is used to bill for services covered under section 1861(a)(1) by persons entitled to payment for such services. 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 CMS1500 (submitted by providers) and CMS-1490S (submitted by beneficiaries) meets this need.

## 2. Information Users

The CMS-1500 and the CMS-1490S forms are used to deliver information to CMS in order for CMS to reimburse for provided services. 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 Medical Payment) was explicitly developed for easy use by beneficiaries who file their own claims. The English and Spanish version CMS-1490S form (version 01/18) can be obtained from a Medicare Administrative Contractor or online by accessing the following link: <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMSForms-Items/CMS012949>

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 summary, 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.

3. Improved Information Technology

The CMS-1500 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 scanned 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 nonelectronic 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. Approximately 96.5% of small business submit electronic claims forms to Medicare, leaving only a small percentage that submit via paper. Therefore, there is no significant impact on small businesses.

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.

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 CMS1500, inflicting a severe administrative burden and financial hardship on providers/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

The 60-day Federal Register Notice was published, Federal Register (89 FR 32433) on April 26, 2024.

The 30-day Federal Register Notice was published the Federal Register (89 FR 56754) on July 10, 2024 .

General collection guidelines:

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

#### Outside consultation:

The 1490S was developed and is maintained by CMS. No outside consultation was involved in the development of this form.

The CMS-1500 was developed based upon consultation with the Uniform Claim Task Force members. This task force was replaced by the National Uniform Claim Committee (NUCC) in 1995. This committee is chaired by the American Medical Association (AMA), with CMS as a critical partner. The committee is a diverse group of health care industry stakeholders representing providers, payers, designated standards maintenance organizations, public health organizations, and vendors.

The NUCC 1500 Claim Form, version 02/12 was implemented on April 1, 2014. This revised form was approved in a prior PRA Package.

#### 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 System of Records Notice - SORN number is 09-70-0501

System Name: "Medicare Multi-Carrier Claims System (MCS)," HHS/CMS/OIS  
Note that OIS has been renamed to the Office of Information Technology (OIT).

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 page 4 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, Medicare Administrative Contractors (MACs) 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, 'Multi-Carrier Claims System,' 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 page 4 of the Form 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, Medicare Administrative Contractor (MAC), medical review boards, and other organizations as necessary to administer the Medicare program. For example, it may be necessary to disclose information 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 Medicare 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 worker’s compensation will pay for the treatment. Section 1877(a)(3) of the Social Security Act provides criminal penalties for withholding this information. If you are being treated for a work related injury be sure to check the appropriate box in Section 2 titled ‘Condition Related to’.

#### 11. Sensitive Questions

This data collection does not ask questions of a sensitive nature.

#### 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 2023. During CY 2023, 99.67 percent of the professional Medicare claims were received electronically. Medicare’s Office of Financial Management records for CY 2023 indicate that 2,507,992 providers/suppliers were enrolled in Medicare Part B.

To derive the average cost, we used data from the U.S. Bureau of Labor Statistics’ May 2023 National Occupational Employment and Wage Estimates for all salary estimates (<https://www.bls.gov/oes/current/oes439041.htm> ). In this regard, the

following table presents the median hourly wage, the cost of fringe benefits, and the adjusted hourly wage.

<b>Occupation Title</b>	<b>Occupation Code</b>	<b>Median Hourly Wage (\$/hour)</b>	<b>Fringe Benefit (\$/hour)</b>	<b>Adjusted Hourly Wage (\$/hour)</b>
Insurance Claims and Policy Processing Clerks	43-9041	\$22.55	\$22.55	\$45.10

### **Estimated Annual Burden Hours**

2023 Professional Claim Data pulled from the MAC/CMS Data Exchange (MDX) Portal.

<b>2023 Professional Claim Data</b>	<b>Total Number of Claims</b>	<b>Percentage</b>	<b>Time to Process Claim</b>	<b>Total Burden Hours</b>
Billed on Paper	3,264,009	0.33%	15 minutes	816,002 hrs.
Billed Electronically	990,774,614	99.67%	1 minute	16,512,910 hrs.
<b>Total</b>	994,038,623			17,328,912 hrs.

Medicare does not furnish forms to physicians and suppliers. Physicians and suppliers must purchase the forms. The CMS-1500 form costs on average \$0.05 per claim (two-part form). Medicare does not reimburse providers for their mailing and handling costs. This costs physicians and suppliers between \$0.68-1.00/claim (or an average of \$ 0.68/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

<b>2023 Professional Claim Data</b>	<b>Total Number of Claims</b>	<b>Total Hours to Process the Claims</b>	<b>Median Hourly Wage</b>	<b>Fringe Benefit</b>	<b>Adjusted Hourly Wage</b>	<b>Total Labor Costs</b>
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Billed on Paper	3,264,009	816,002	\$22.55	\$22.55	\$45.10	\$36,801,690.20
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### **Cost of Mailing Forms**

In addition, physicians and suppliers spend approximately \$0.73/claim in resource cost (this figure includes both form costs and mailing). Therefore, based on these numbers, physicians and suppliers spend approximately:

<b>Mail Forms</b>	<b>Number of Claims</b>	<b>Cost of Claim for Forms and Mailing</b>	<b>Total Annual Cost for Forms and Mailing</b>
Paper	3,264,009	*(\$0.73)	\$2,382,727
<b>Total</b>	3,264,009	\$0.73	\$2,382,727

\* This figure was calculated by adding \$0.05 per claim cost to an average mailing cost of \$0.68.

### **Cost Estimate to Process Professional Paper Claims**

<b>2022 Professional Claim Data</b>	<b>Total Number of Claims</b>	<b>Labor Cost (Including fringe and overhead)</b>	<b>Cost of Claim Forms &amp; Mailing</b>	<b>Total Cost to Process Professional Paper Claims</b>
Billed on Paper	3,264,009	\$36,801,690.20	\$2,382,727	\$39,184,417.20

### CMS 1490S

The count of CMS-1490S paper forms is included in the 3,264,009 total and is therefore reflected in the burden figures above. Professionals from the Provider's office usually assist the beneficiaries in filling out the 1490S forms.

### 13. Capital Costs

There are no capital costs.

### 14. Cost to Federal Government

The calculations for OIT employees' hourly salary were obtained from the OPM website, with an additional 100% to account for fringe benefits.

Hourly Wage: \$34.76 + 100% fringe benefits = \$69.52

<b>Task</b>	<b>Estimated Cost</b>
Acquiring and Preparing the Required Data and Oversight	
1 GS-11: 1 x \$69.52 x 20 hours	\$1,390.40
<b>Total Costs to Government</b>	<b>\$1,390.40</b>

#### 15. Program Changes/Burden Changes

The reported decrease in the paper claims processed from the previous reporting period is once again due to the enforcement of mandatory electronic claim submission requirements, which are part of the 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. Consequently, unless a provider fits one of the approved exceptions, any paper claims submitted to Medicare will not be paid.

The burden changes reported are due to the cost per hour wages have increased from the previous reporting period CY 2022 to CY 2023 used in this package. This estimate takes into account labor and resource cost based on the Bureau of Labor and Statistics (BLS) Occupational and Employment Data for Category 43-9041 Insurance Claims and Policy Processing Clerks. To account for fringe and overhead, we added 100% of the hourly median hourly labor wage to get an adjusted cost burden of \$45.10 (\$22.55 + \$22.55) per hour.

The cost for purchasing the claim form decreased by \$0.02 and the price per postage increased by \$0.05. The CMS-1500 form costs on average \$0.05 per claim and the average mailing cost is \$0.68.

#### 16. Publication and Tabulation Dates

Quality data reporting by claims-based submission is allowed using the CMS-1500 and its electronic equivalent. Those who choose claims-based submission (other submission methods exist) will submit the information for the quality measures on their claim form. Data is retrieved from the National Claims History file to facilitate the provision of information on the quality and effectiveness of care provided. Generalized claims data are made public by CMS.

#### 17. Expiration Date

The CMS Form 1500 is maintained by the National Uniform Claim Committee (NUCC). The current version of the form is 02/12. The form is clearly marked that it was approved by the NUCC in 02/12 and there have been no changes to the CMS Form 1500 since its approval in 02/12.

The CMS Form 1500 is used widely throughout the industry by commercial, state Medicaid's, workers' compensation, property and casualty insurance plans, in addition to federal health plans. While OMB approval is needed for the form to be used by federal programs, it is not necessary for other health plans that use the form. Requiring the OMB expiration date on all CMS Form 1500s would impact a large sector of non-federal health plan users of the form.

The Administrative Simplification and Compliance Act permits a provider of services with fewer than 25 FTE (defined by 1861(u) of the Social Security Act) or fewer than 10 FTE physician that is not otherwise a provider under section 1861(u) to submit paper CMS Form 1500 claims to Medicare, recognizing the potential cost that electronic billing systems may present to small providers. Since these providers would presumably not have the overhead to adopt an electronic billing platform, an expiration date on a stock of forms could have a particularly burdensome impact on the resources of these providers.

The CMS Form 1500 cannot be printed for use by individual providers. The CMS Form 1500 must be purchased from print vendors, the forms are usually packaged in packs as small as 100 and up to packs of 15,000 with a cost range from \$7.00 up to \$1,050.00 depending on the size of the package of claim forms purchased.

Regardless of how frequently they are used, any physician practice, other group practice, hospital, other facility, supplier, and other user of the 1500 form could be required to purchase new forms with the OMB expiration date included on it. Purchases of new forms would be required every three years with each OMB renewal because of an updated expiration date only. There is already confusion about the meaning of the OMB renewal of the form.

Per Wikipedia, there are approximately 230,000 physician practices in the U.S. If 200,000 practices had to replace a modest number of forms, such as 500, the cost would be (1 package of 500 x \$30 x 200,000) \$6 million.

The supportive information stated here, attests that the CMS Form 1500 is to be exempt from requiring an expiration date.

The electronic version of the CMS Form 1500 is the Health Care Claim: Professional (837p). The 837P is a statutory electronic claim that is adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA allows for updates to the 837P. When the 837P is updated via the Federal rulemaking process,

the effective date of the updated 837P is contained in the Final Rule. The effective date for the updated 837P version, by reference, establishes the expiration date of the prior version.

18. Certification Statement

There are no exceptions to the certification statement.