CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1144	**Date: DECEMBER 29, 2006**
	Change Request 5390

Subject: Elimination of CMS-1491 and CMS-1490U Forms

I. SUMMARY OF CHANGES: CMS-1491 and CMS 1490U are paper claim forms used by a small number of suppliers to submit their claims. CMS promulgated changes to 42 CFR (section)424.32 to cease the printing of CMS 1491 and CMS 1490U, effective October 1, 2006. As of April 2, 2007, suppliers are no longer permitted to submit paper claims on the CMS-1491 and CMS 1490U forms. Chapter 1, Section 70.8.4 is being revised to eliminate all information that pertains to CMS-1491 and CMS 1490U forms. Chapter 15, Section 30.1.3 is being revised to add a paragraph informing contractors that CMS-1941 is no longer valid format for summiting claims effective April 2, 2007.

New / Revised Material
Effective Date: April 2, 2007
Implementation Date: April 2, 2007

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	1/70.8.4/Claim Forms
R	15/30.1.3/Coding Instructions for Form CMS-1491

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1144	Date: December 29, 2006	Change Request 5390

SUBJECT: Elimination of Form CMS-1491 and CMS-1490U

Effective Date: April 2, 2007

Implementation Date: April 2, 2007

I. GENERAL INFORMATION

A. Background: Form CMS-1491 and CMS-1490U are paper claim forms currently used by a small number of suppliers to submit their claims. A very small number of suppliers currently use the CMS-1491 and CMS 1490U forms and the agency determined that there would be considerable cost in redesigning these forms to accept the National Provider Identifier. Therefore, CMS promulgated changes to 42 CFR § 424.32 to cease the printing of CMS-1491 and CMS-1490U, effective October 1, 2006.

B. Policy: As of April 2, 2007, suppliers are no longer permitted to submit paper claims on the Form CMS-1491 and CMS-1490U. Suppliers that wish to submit a paper claim must use the Form CMS-1500.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5390.1	Contractors shall not accept CMS-1491 and CMS 1490U forms for dates of receipt on or after April 2, 2007	X			X							
5390.2	Contractors shall reject Form CMS-1491 received on or after April 2, 2007 and request that the CMS claim be re-submitted electronically or on the Form CMS-1500 (version 08/05).	X			X							
5390.3	Contractors shall reject Form CMS-1490U received on or after April 2, 2007 and request that the CMS claim be re-submitted electronically	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	or on the Form CMS-1500 (version 08/05).											

III. PROVIDER EDUCATION TABLE

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Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5390.4	A provider education article related to this instruction will be available at www.cms.hhs.gov/MLNMattersArticles shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X							

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

B. For all other recommendations and supporting information, use the space below:

V. CONTACTS

Pre-Implementation Contact(s): Wendy Knarr at Wendy.Knarr@cms.hhs.gov or Joan Proctor Young at 410-786-0949 or Joan.Proctoryoung@cms.hhs.gov
Post-Implementation Contact(s): Your Appropriate RO

VI. FUNDING

A. *For TITLE XVIII Contractors*, use only one of the following statements:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use only one of the following statements:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. We do not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts specified in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

70.8.4 - Claims Forms

(Rev. 1144, Issued: 12-29-06, Effective: 04-02-07, Implementation: 04-02-07)

A number of prescribed claims forms have been developed for use when requesting payment for Part B Medicare services. Many are printed and distributed nationally free of cost through CMS's Printing and Publications Branch. (See NOTE below for exception.)

In order to maintain control over the content and format of the forms, private printing of a Government form is not routinely permitted. However, if you or another organization wishes to independently print a prescribed claims form, the reproduction of a claims form must be in accordance with §422.527 of Title 20, Chapter III, Part 422 of the Code of Federal Regulations. Obtain CMS approval for printing a prescribed form. Route the written request for approval through the RO. Include the following:

- The reason or need for such reproduction;
- The intended user of the form;
- The proposed modifications or format changes, with printing or other specifications (such as realignment of data or line designations);
- The type of automatic data processing machinery, if any, for which the form is designed; and
- Estimates of printing quantity, cost per thousand, and annual usage.

NOTE: This procedure does not apply to the Form CMS-1500, Health Insurance Claim Form. Carriers, physicians and suppliers are responsible for purchasing their own forms. This form can be bought in single, multipart snap-out sets or in continuous pin-feed format. Medicare accepts any version. Forms can be obtained from local printers or printed in-house as long as it follows the CMS approved specifications developed by the American Medical Association.

The Form CMS-l490 was formerly the basic Part B claims form. It was replaced by Form CMS-l500 for claims completed by physicians and suppliers (except ambulance suppliers), and Form CMS-l490S for claims from beneficiaries. You must, however, continue to accept and process claims received on Form CMS-1490 form after conversion to Forms CMS-l500 and CMS-l490S.

The Form CMS-1500 (Health Insurance Claim Form), sometimes referred to as the AMA form, is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance services), whether or not the claims are assigned. It can be purchased in any version required i.e., single sheet, snap-out, continuous, etc.

The forms described below are printed and distributed to contractors by CMS and are available in single sheets, multipart snap-out sets, or in pin-feed format.

The Form CMS-1490S (Patient's Request for Medicare Payment) form is used only by beneficiaries (or their representatives) who complete and file their own claims. It contains only the first six comparable items of data that are on the Form CMS-1500. When the Form CMS-1490S is used, an itemized bill must be submitted with the claim. Social Security Offices use the Form CMS-1490S when assisting beneficiaries in filing Part B Medicare claims. For Medicare covered services received on or after September 1, 1990, the Form CMS-1490S is used by beneficiaries to submit Part B claims only if the service provider refuses to do so. Inasmuch as the Form CMS-1490S has no provision for an ICD-9 code, the ICD-9 code is not required at the time of claim submission.

The Form CMS-1556 (Prepayment Plan for Group Practices Dealing Through A Carrier) is used by plans which, for Medicare purposes are, both Group Practice Prepayment Plans, and are paid on the basis of reasonable charges related to their costs for furnishing services to their subscribers.

30.1.3 - Coding Instructions for Form CMS-1491

(Rev. 1144, Issued: 12-29-06, Effective: 04-02-07, Implementation: 04-02-07)

Effective April 2, 2007, Form CMS-1941 will no longer be a valid format for submitting claims. Suppliers who wish to submit a paper claim must use Form CMS-1500.

For claims with Dates of Receipt prior to April 2, 2007:

Form CMS-1491 has not been revised for the new fee schedule. The following coding instructions should be followed until the form is revised.

The service HCPCS code is entered into item 22 as well as any information necessary to describe the illness or injury.

The new HCPCS code must be used to reflect the type of service the beneficiary received, not the type of vehicle used.

There is no grace period to transition the use of the new HCPCS codes. Carriers return as unprocessable any claim submitted with old HCPCS codes for dates of service January 1, 2001, and later (with the exception of those HCPCS codes for items and services that Methods 3 and 4 billers may continue to bill through transition years 1, 2, 3, and 4).

Generally, a claim for an ambulance service will require two entries, e.g., one HCPCS code for the service and one HCPCS code for the mileage. Suppliers who do not bill mileage would have an entry only for the service.

The mileage HCPCS code is entered into item 14 as well as the number of loaded miles.

If mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code “1” as the mileage for trips less than a mile

NOTE: To bill mileage, providers and suppliers continue to use codes A0380 and A0390 for dates of service January 1, 2001 through March 31, 2002.

Suppliers using Method 3 or 4 may use supply codes A0382, A0384, and A0392 - A0999 as well as J-codes and codes for EKG testing during the transition period. These supply codes should be entered in item 22. Carriers deny claims for items from Method 1 and Method 2 billers.

The ZIP code of the point of pickup must be entered in item 12. If there is no ZIP code in item 12, or if there are multiple ZIP codes in item 12, carriers return the claim as unprocessable.

The ZIP code entered in item 12 must be edited for validity.

The format for a ZIP code is five numerics. If the ZIP code in item 12 shows a 9-digit ZIP code, carriers validate only the first 5 digits. If the ZIP code entered into item 12 does not correspond to a USPS either 5- or 9-digit format, carriers reject the claim as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

If the ZIP code entered on the claim is not in the CMS-supplied ZIP Code File, manually verify the ZIP code to identify a potential coding error on the claim or a new ZIP code established by the U.S. Postal Service (USPS). ZIP code information may be found at the USPS Web site at http://www.usps.com/, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. All such ZIP codes are to be considered urban ZIP codes until CMS determines that the code should be designated as rural. If this process does not validate the ZIP code, the claim must be rejected as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.