CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1247	**Date: MAY 25, 2007**
	Change Request 5616

Subject: New Deadline for Required Submission of the Form CMS-1500 (08-05)

I. SUMMARY OF CHANGES: CMS is instructing contractors to reject the Form CMS-1500 (12-90) claims received starting July 2, 2007.

New / Revised Material
Effective Date: July 1, 2007
Implementation Date: July 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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

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:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 1247	Date: May 25, 2007	Change Request: 5616

SUBJECT: New Deadline for Required Submission of the Form CMS-1500 (08-05)

Effective Date: **July 1, 2007**

Implementation Date: July 2, 2007

I. GENERAL INFORMATION

On March 19, 2007, CMS released Transmittal 1208, CR5568, which instructed Medicare contractors to continue to accept the Form CMS-1500 (12-90) version due to reports of an incorrectly printed version of the Form CMS-1500 (08-05) that was being sold by some print vendors. Although a tentative date was set at June 1, 2007, CMS intended to gather and review statistics from our contractors in an effort to set a new deadline. The information gathered from our contractors indicates to us that the problem is not as widespread as previously suspected.

Based on the information at hand, providers will now be required to begin submitting the Form CMS-1500 (08-05) only beginning July 2, 2007. It is important to note that this transmittal requires the submission of the revised Form CMS-1500 paper claim form only, and has no bearing on the implementation of the National Provider Identifier (NPI) nor mandates the submission of the NPI by July 2, 2007.

A. Background: In March 2007, Medicare announced that due to format issues the previous version of the Form CMS-1500 (12-90) would continue to be accepted tentatively until June 1, 2007.

B. Policy: The Form CMS-1500 answers the needs of many health insurers. It is the paper claim form prescribed by CMS for use by physicians and suppliers that qualify for an exemption from the mandatory electronic claims submission requirements set forth in the Administrative Simplification Compliance Act, Pub.L. 107-105 (ASCA) and the implementing regulation at 42 CFR 424.32.

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	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5616.1	Contractors shall set up a process to manually reject Form CMS-1500 (12-90) claims, received on or after July 2, 2007, and request that the claims be resubmitted on the Form CMS-1500 (08/05). This business requirement supercedes BR5568.1 and replaces BR5060.4.	X	X		X	X						

III. PROVIDER EDUCATION TABLE

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	
5616.2	A provider education article related to this instruction will be available at http://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. In addition, the provider education article shall be included in your next regularly scheduled bulletin. 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		X	X						

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Brian Reitz, 410-786-5001, Brian.Reitz@cms.hhs.gov

Post-Implementation Contact(s): Brian Reitz, 410-786-5001, Brian.Reitz@cms.hhs.gov

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:
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 the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does 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 allotted 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.