| 1 | 2 | 3a PAT. CNTL # | 4 TYPE OF BILL |
|---|---|---|---|
| | | b. MED. REC. # | |
| | | 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM THROUGH |
| | | | 7 |

| 8 PATIENT NAME | a | 9 PATIENT ADDRESS | a |
|---|---|---|---|
| b | | b | c d e |

| 10 BIRTHDATE | 11 SEX | 12 ADMISSION DATE | 13 HR | 14 TYPE | 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29 ACDT STATE | 30 |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

| | 31 OCCURRENCE CODE DATE | 32 OCCURRENCE CODE DATE | 33 OCCURRENCE CODE DATE | 34 OCCURRENCE CODE DATE | 35 OCCURRENCE SPAN CODE FROM THROUGH | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37 |
|---|---|---|---|---|---|---|---|
| a | | | | | | | a |
| b | | | | | | | b |

| 38 | | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT |
|---|---|---|---|---|
| | a | | | |
| | b | | | |
| | c | | | |
| | d | | | |

| | 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATE / HIPPS CODE | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | 1 |
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| 23 | | ***PAGE ____ OF ____*** | ***CREATION DATE*** | | ***TOTALS*** | | | | 23 |

| | 50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL. INFO | 53 ASG. BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI | | |
|---|---|---|---|---|---|---|---|---|---|
| A | | | | | | | 57 | | A |
| B | | | | | | | OTHER | | B |
| C | | | | | | | PRV ID | | C |

| | 58 INSURED'S NAME | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO. |
|---|---|---|---|---|---|
| A | | | | | A |
| B | | | | | B |
| C | | | | | C |

| | 63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME |
|---|---|---|---|
| A | | | A |
| B | | | B |
| C | | | C |

| 66 DX | 67 | A | B | C | D | E | F | G | H | 68 |
|---|---|---|---|---|---|---|---|---|---|---|
| | I | J | K | L | M | N | O | P | Q | |

| 69 ADMIT DX | | 70 PATIENT REASON DX | a | b | c | 71 PPS CODE | | 72 ECI | a | b | c | 73 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

| 74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75 |
|---|---|---|---|
| | | | |
| c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE | |
| | | | |

| 80 REMARKS | 81CC | | |
|---|---|---|---|
| | a | | |
| | b | | |
| | c | | |
| | d | | |

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|---|---|---|---|---|
| 76 ATTENDING | NPI | | QUAL | |
| LAST | | FIRST | | |
| 77 OPERATING | NPI | | QUAL | |
| LAST | | FIRST | | |
| 78 OTHER | NPI | | QUAL | |
| LAST | | FIRST | | |
| 79 OTHER | NPI | | QUAL | |
| LAST | | FIRST | | |

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997

NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

**UB-04 NOTICE:** **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:

   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;

   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;

   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;

   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;

   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and

   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

**Supporting Statement – Part A**

**Supporting Regulations Contained in 42 CFR 424.5 for the Uniform Institutional Providers Form**
**(CMS-1450 (UB-04); OMB-0938-0997)**

## A. Background

All paper claims processed by Part A Medicare Administrative Contractors (MACs) must be submitted on the UB-04 CMS-1450 after May 23, 2007. Data fields in the X12 837 data set are consistent with the UB-04 CMS-1450 data set. The Centers for Medicare and Medicaid Services (CMS) is requesting an OMB extension of the currently approved collection for an additional three years.

## B. Justification

### 1. Need and Legal Basis

The basic authorities which allow providers of service to bill for services on behalf of the beneficiary are section 1812 (42 USC 1395d - http://www.gpo.gov/fdsys/granule/USCODE-2009-title42/USCODE-2009-title42-chap7-subchapXVIII-partA-sec1395d) (a) (1), (2), (3), (4) and 1833 (2) (B) of the Social Security Act). Also, section 1835 (42 USC 1395n) requires that payment for services furnished to an individual may be made to providers of services only when a written request for payment is filed in such form as the Secretary may prescribe by regulations. Section 42 CFR 424.5(a)(5) requires providers of services to submit a claim for payment prior to any Medicare reimbursement. Charges billed are coded by revenue codes. The bill specifies diagnoses according to the International Classification of Diseases, Tenth Edition (ICD-10) code. Inpatient procedures are identified by ICD-10 codes, and outpatient procedures are described using the CMS Common Procedure Coding System (HCPCS). These are standard systems of identification for all major health insurance claims payers. Submission of information on the UB-04 CMS-1450 permits Medicare Part A MACs to receive consistent data for proper payment.

### 2. Information Users

The UB-04 CMS-1450 is managed by the National Uniform Billing Committee (NUBC), sponsored by the American Hospital Association. Most payers are represented on this body, and the UB-04 is widely used in the industry. Medicare receives 99.97 percent of the Part A claims submitted by institutional providers electronically. Because of the number of small and rural providers who do not submit claims electronically, it is not possible to achieve total electronic submission at this time. Medicare Part A MACs use the information on the UB-04 CMS-1450 to determine whether to make Medicare payment for the services provided, the payment amount, and whether or not to apply deductibles to the claim. The same method is also used by other payers. CMS is also a secondary user of data. CMS uses the information to develop a database, which is

used to update, and revise established payment schedules and other payment rates for covered services. CMS also uses the information to conduct studies and reports.

3. Use of Information Technology

Medicare receives over 99.97 percent of the claims submitted by institutional providers electronically. CMS only accepts electronic claims in the Accredited Standards Committee (ASC) Health Insurance Portability and Accountability Act (HIPAA) 837 format for institutional providers unless the provider meets CMS requirements to submit paper claims. With the uniform bill, we have been able to achieve a more uniform and a more automated bill processing system for Medicare institutional and providers. This form is consistent with the CMS electronic billing specifications, i.e., all coding data element specifications are identical. This has promoted and eased the conversion to electronic billing. Provider billing costs have decreased as a result of standardization of bill preparation, related training and other activities.

- Is this collection currently available for completion electronically? **Yes. Medicare receives over 99.97 percent of the claims submitted by institutional providers electronically.**
- Does this collection require a signature from the respondent(s)? **No.**
- If CMS had the capability of accepting electronic signature(s), could this collection be made available electronically? **N/A.**
- If this collection is not currently electronic but will be made electronic in the future, please give a date (month & year) as to when this will be available electronically and explain why it cannot be done sooner. **N/A.**
- If this collection cannot be made electronic or if it is not cost beneficial to make it electronic, please explain. **N/A.**

4. Duplication of Efforts

Most hospitals participate in both Medicare and many other insurance programs and, without use of the UB-04 CMS-1450, would have to maintain distinct and duplicate billing systems to handle the billing form, and the diagnostic coding systems for the many programs. The purpose of the requirements in this package is to eliminate this duplication. There is no one form that can accommodate as much information as the UB-04 CMS-1450 does; nor is there another that can handle a variety of services the way the uniform bill does. The UB-04 CMS-1450 is managed by the National Uniform Billing Committee, a standard's body sponsored by the American Hospital Association.

5. Small Businesses

Burden can be minimized by providing training materials and by obtaining assistance from the uniform bill coordinator designated by each CMS regional office.

6. Less Frequent Collection

There will always be a very small percentage of institutional providers that need to submit paper claims to Medicare for reimbursement of services rendered to patients who are covered under the Medicare Program. Therefore, the form must continue to be available for use. Form usage has declined significantly since the last collection.

7. Special Circumstances

There are no special circumstances.

8. Federal Register/Outside Consultation

The 60-day Federal Register Notice published in the Federal Register on 4/16/2019 (84 FR 15618).
The collection received zero comments during the comment period.

The 30-day Federal Register Notice published in the Federal Register on INSERT (84 FR INSERT).

9. Payments/Gifts to Respondents

The UB-04 CMS-1450 must be used to receive payment for the provision of the institutional health care claims. 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

Privacy Act requirements have already been addressed under a Notice Systems of Record entitled "Intermediary Medicare Claims Record" system number 09-70-0503, DHHS/CMS/OIS. Note that OIS has been renamed to the Office of Information Technology (OIT).

11. Sensitive Questions

No questions of a sensitive nature are asked.

12. Burden Estimates (Hours & Wages)

To derive average costs, we used data from the U.S. Bureau of Labor Statistics' May 2017 National Occupational Employment and Wage Estimates for all salary estimates (www.bls.gov/oes/current/oes_nat.htm). In this regard, the following table presents the mean hourly wage, the cost of fringe benefits, and the adjusted hourly wage.

| Occupation Title | Occupation Code | Mean Hourly Wage ($/hour) | Fringe Benefit ($/hour) | Adjusted Hourly Wage ($/hour) |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| Office Clerks | 43-9061 | $16.69 | $16.69 | $33.38 |

Based on CMS's 2018 Contractor Reporting of Operational and Workload Data (CROWD) System' institutional claims' data, 214,595,906 of all Medicare institutional claims (99.97%) were billed electronically and 64,392 of all Medicare institutional claims (0.03%) were billed on paper. Estimate of burden results are as follows:
Processing 64,392 paper claims @ 9 minutes per paper claim = 9,659 hours
Processing 214,595,906 electronic claims @ 0.5 minutes per paper claim = 1,788,299 hours

9,659 Paper burden hours
1,788,299 Electronic burden hours
---
1,797,958 Total burden hours

For 2018, there were 64,392 paper claims per year totaling 9,659 annual hours per year @ $16.69 per hour = $161,205.27. We have added fringe and overhead at 100% ($33.38 x 9,659 hours) = $322,410.54. We have added 100% of the mean hourly wage to account for fringe and overhead benefits.

13. Capital Costs

There is no capital or operational costs associated with this collection.

14. Cost to Federal Government

The annual costs to the Federal government for the information collection activity include all aspects of the data collection function from the initial data entry to receipt/processing operations. The costs to the Federal Government for data collection can best be described as the total costs of processing the required billing information. Calculation of the precise costs for the data collection is not feasible for the purposes of the Paperwork Reduction Act without conducting a costly study. Therefore, aggregate costs have been developed taking into consideration programming, software, training, tapes, overhead costs, etc.

15. Changes to Burden

The number of UB-04 CMS-1450 paper claims was greatly reduced and the number of electronic claims has increased. We have adjusted the burden accordingly.

16. Publication/Tabulation Dates

The purpose of this data collection is payment to providers for Medicare services rendered. We do not employ statistical methods to collect this information, but rather all Medicare institutional providers generate this billing information subsequent to the delivery of services.

17. Expiration Date

Previous forms have been cleared without the expiration date present. Placing the expiration date on the form would require form changes. Since CMS is not responsible for the design and content of the UB-04 CMS-1450, we would have to seek approval from the NUBC, which has responsibility for the UB-04 CMS-1450, to make the change.

18. Certification Statement

There are no exceptions to the certification statement.