

# CMS Manual System

## Pub 100-04 Medicare Claims Processing

Transmittal 1104

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: NOVEMBER 3, 2006

Change Request 5072

*NOTE: Transmittal 1018, dated July 28 2006, is rescinded and replaced with Transmittal 1104, dated November 3, 2006. (In BR 5072.2(3<sup>rd</sup> line) it reads FL3a, when it should correctly read: FL3b. In BR5072.2.1(2<sup>nd</sup> line) it also reads FL3a, when it should correctly read: FL3b. All other information remains the same.*

### SUBJECT: Uniform Billing (UB-04) Implementation

**I. SUMMARY OF CHANGES:** The CMS needs to be ready to receive the new UB-04 by March 1, 2007. Institutional providers can use the UB-04 beginning March 1, 2007, however, they will have a transitional period between March 1, 2007 and May 22, 2007 where they can use the UB-04 or the UB-92. Starting May 23, 2007 all institutional paper claims must use the UB-04. The UB-92 will no longer be accepted after this date. The UB-04 incorporates the National Provider Identifier (NPI), taxonomy, and additional codes (note the attached crosswalk file). Many UB-92 data locations have changed on the UB-04 although most of the data usage descriptions and allowable data values have not changed. Bill type processing will change. Note that this CR does not expand the claim record used for processing. Starting May 23, 2007, all UB-04s must include a valid NPI.

#### New / Revised Material

Effective Date: March 1, 2007

Implementation Date: March 1, 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	25/TOC/Completing and Processing the CMS 1450 Data Set
R	25/50/Uniform Bill (UB) - Form CMS-1450 for Billing (UB-92)
R	25/60/General Instructions for Completion of Form CMS-1450 for Billing (UB-92)
R	25/70.1/Uniform Billing with form CMS-1450
R	25/70.2/Disposition of Copies of Completed Forms
R	25/75/General Instructions for Completion of Form CMS-1450 (UB-04)
R	25/75.1/Form Locators 1-15



## Electronic Billing & EDI Transactions

- Overview
- Electronic Data Interchange System Access and Privacy
- Electronic Data Interchange (EDI) Support
- How to Enroll in Medicare Electronic Data Interchange
- Administrative Simplification Compliance Act Enforcement Reviews
- Administrative Simplification Compliance Act Self Assessment
- Administrative Simplification Compliance Act Waiver Application
- Electronic Health Care Claims Eligibility Inquiry
- Claim Status Request and Response
- Health Care Payment and Remittance Advice
- Coordination of Benefits
- Electronic Funds Transfer

## Institutional paper claim form (CMS-1450)

The CMS-1450 form (aka UB-92 at present) can be used by an institutional provider to bill a Medicare fiscal intermediary (FI) when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. It is also used for billing of institutional charges to most Medicaid State Agencies. Please contact your Medicaid State Agency for more details on their requirements for this paper form.

The National Uniform Billing Committee (NUBC) is responsible for the design of the form, and award of the contract for printing of the form. You may obtain copies of the CMS-1450 form, which is also known as the UB-92, from the Standard Register Company, Forms Division. Their phone number may be found in your local yellow pages. Blank copies of the form may also be available through office supply stores in your geographic area. Although a copy of that form can be downloaded, copies of the form should not be downloaded for submission of claims, since your copy may not accurately replicate colors included in the form. These colors are needed to enable automated reading of information on the form.

You can find Medicare CMS-1450 UB-92 completion and coding instructions in Chapter 25 of the Medicare Claims Processing Manual (Pub.100-04). The UB-92 will not be accepted by CMS after May 22, 2007.

The NUBC is updating the UB-92; it will be replaced by the UB-04 paper form. During the period March 1, 2007 through May 22, 2007, providers that use paper forms for claim submission will be able to submit either the UB-92 or the UB-04 form. CMS expects to discontinue acceptance of UB-92 forms effective May 23, 2007. HIPAA requires submission of National Provider Identifiers (NPIs) on claims effective May 23, 2007, and the UB-92 does not have a field for reporting of NPIs. The dates of this transition period were established by the NUBC. Further information on the UB-92 and the UB-04 is available through the NUBC web site. A link is provided below. The UB-04 will retain the CMS-1450 designation.

CMS has received Office and Management and Budget approval for the UB-04, as required under the Paperwork Reduction Act. You can find Medicare CMS-1450 UB-04 completion and coding instructions in Chapter 25 of the Medicare Claims Processing Manual (Pub.100-04).

Electronic Claims Attachments

**Institutional paper claim form (CMS-1450)**

Professional paper claim form (CMS-1500)

Contingency

The UB-04 will be the only hardcopy claims format accepted by CMS after May 22, 2007.

See Medicare Claims Processing Manual, (Pub.100-04), Chapter 25 for further information.

**Downloads**

There are no Downloads

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Centers for Medicare & Medicaid Services, 7500 Security Boulevard Baltimore, MD 21244

www2

# NEW UB-04

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH	
8 PATIENT NAME	9 PATIENT ADDRESS	a	b
10 BIRTHDATE	11 SEX	12 DATE	13 ADMISSION 19 RR 14 TYPE
15 SRC	16 DHR	17 STAT	18 19 20 21
22	23	24	25
26	27	28	29 ACCT STATE
30	31 OCCURRENCE DATE	32 OCCURRENCE DATE	33 OCCURRENCE DATE
34	35 CODE	36 OCCURRENCE SPAN FROM	37 THROUGH
38	39 CODE	40 VALUE CODES AMOUNT	41 CODE
42	43	44	45
46	47	48	49
50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.
54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	57 OTHER PRV ID
58 INSURED'S NAME	59 R. REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME
62 INSURANCE GROUP NO.	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
66 DX	67	68	69
70 PATIENT REASON DX	71 FPS CODE	72 ECI	73
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 QUAL
78 LAST	79 FIRST	80 LAST	81 FIRST
82 OTHER PROCEDURE CODE	83 OTHER PROCEDURE CODE	84 OTHER PROCEDURE CODE	85 OTHER PROCEDURE CODE
86 LAST	87 FIRST	88 LAST	89 FIRST
90 OTHER PROCEDURE CODE	91 OTHER PROCEDURE CODE	92 OTHER PROCEDURE CODE	93 OTHER PROCEDURE CODE
94 LAST	95 FIRST	96 LAST	97 FIRST
98 OTHER PROCEDURE CODE	99 OTHER PROCEDURE CODE	100 OTHER PROCEDURE CODE	101 OTHER PROCEDURE CODE
102 LAST	103 FIRST	104 LAST	105 FIRST
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# OLD UB-92

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2		3 PATIENT CONTROL NO.										4 TYPE OF BILL													
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM			7 COV. D.		8 N-C.D.		9 C-I.D.		10 L-R.D.		11												
12 PATIENT NAME										13 PATIENT ADDRESS															
14 BIRTHDATE		15 SEX	16 MS	17 DATE		ADMISSION 18 HR		19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.			24	25	26	27	28	29	30	31			
32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37 OCCURRENCE SPAN FROM		37													
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42 REV. CD.	43 DESCRIPTION					44 HCPCS / RATES			45 SERV. DATE	46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49									
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50 PAYER					51 PROVIDER NO.			52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56											
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57										<b>DUE FROM PATIENT</b>															
58 INSURED'S NAME					59 P. REL.	60 CERT. - SSN - HIC. - ID NO.			61 GROUP NAME			62 INSURANCE GROUP NO.													
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63 TREATMENT AUTHORIZATION CODES					64 ESC	65 EMPLOYER NAME			66 EMPLOYER LOCATION																
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67 PRIN. DIAG. CD.		68 CODE		69 CODE		70 CODE		OTHER DIAG. CODES 71 CODE		72 CODE		73 CODE		74 CODE		75 CODE		76 ADM. DIAG. CD.		77 E-CODE		78			
79 P.C.		80 PRINCIPAL PROCEDURE CODE		81 OTHER PROCEDURE CODE		82 OTHER PROCEDURE CODE		83 OTHER PROCEDURE CODE		84 OTHER PROCEDURE CODE		85 OTHER PROCEDURE CODE		86 OTHER PROCEDURE CODE		87 OTHER PROCEDURE CODE		88 OTHER PROCEDURE CODE		89 OTHER PROCEDURE CODE		90			
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84 REMARKS										85 PROVIDER REPRESENTATIVE		86 DATE													
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Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or 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 particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.
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 Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanatorium services are on file.
5. Signature of patient or his/her 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 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.
6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing 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 their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes:

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

This is to certify that:

- (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;
- (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance 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 coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;
- (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS 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 but excluding contract surgeons or other personnel employed by the Uniformed Services through 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 the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.
- (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, 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. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

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ESTIMATED CONTRACT BENEFITS