JANET T. MILLS
GOVERNOR

MHDO Maine Health Data Organization
Information | Insight | Improvement

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**Date:** March 19, 2024

**Submitted To:** Senator Bailey, Representative Perry, and Members of the Joint Standing Committee on Health Coverage, Insurance and Financial Services
Office of Affordable Health Care

**CC:** Colleen McCarthy Reid, Esq. Principal Legislative Analyst
Bethany Beausang, Senior Policy Advisor, Office of Governor Janet T. Mills
Joel Allumbaugh, Chair MHDO Board of Directors
Commissioner Head, Vice-Chair, MHDO Board of Directors

**From:** Karynlee Harrington, Executive Director, Maine Health Data Organization

**RE:** First Annual Facility Fees Report

Public Law 2023, Chapter 410 (LD1795), *An Act to Create Greater Transparency for Facility Fees Charged by Health Care Providers and to Establish the Task Force to Evaluate the Impact of Facility Fees on Patients*, requires the Maine Health Data Organization (MHDO) to submit an annual report on payments for facility fees made by payers, to the extent that payment information is already reported to the organization, to the Office of Affordable Health Care and the Joint Standing Committee on Health Coverage, Insurance and Financial Services.

Attached is a copy of our first annual report.

I want to thank the committee and the office of affordable health care for your patience as we developed our first annual report on this topic.

Please do not hesitate to contact me directly with any questions. Karynlee

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# Overview

Public Law 2023, Chapter 410 (LD1795), *An Act to Create Greater Transparency for Facility Fees Charged by Health Care Providers and to Establish the Task Force to Evaluate the Impact of Facility Fees on Patients*, requires the Maine Health Data Organization (MHDO) to submit an annual report on payments for facility fees made by payers, to the extent that payment information is already reported to the organization, to the Office of Affordable Health Care and the Joint Standing Committee on Health Coverage, Insurance and Financial Services.

Under contract with MHDO, Human Services Research Institute (HSRI) provided MHDO technical support in the preparation of this report.

MHDO's first annual report on facility fees is a two-part report: Part-one provides the reader with a general understanding of definitions and standards specific to healthcare billing practices and the specific data elements in the MHDO's all-payer claims data (APCD) that allow MHDO to identify a payment for health care services rendered within a hospital (in billing referred to as a facility setting /institutional setting) and services provided by a healthcare provider (in billing referred to as a professional setting /non-institutional setting). Part-two of the report is an overview of MHDO's observations specific to the analysis of thousands of data points from MHDO's health care cost and quality website, CompareMaine. Using those data, MHDO looked at the proportion of payments that are billed on a CMS 1500 vs. a UB-04, the specific procedure associated with the payment, the health care setting where the service was provided and the ownership of the health care setting.

# MHDO's Purpose

MHDO's mandate, described in Title 22, Chapter 1683, is to create and maintain a useful, objective, reliable, and comprehensive health information data warehouse that is used to improve the health of Maine citizens and to promote transparency of the cost and quality of health care in the State of Maine, in collaboration with the Maine Quality Forum.

MHDO is responsible for the collection, storage, management, and release of healthcare data, which includes claims data from public and commercial payers, prescription drug pricing data, hospital inpatient and outpatient encounter data, hospital and nursing home quality data, and hospital financial and organizational data. MHDO maintains over 1 billion healthcare records and that number grows every month as new data are submitted. For years, MHDO's data have been an important data source for a broad set of authorized data users in their analysis of health care costs, utilization, and outcomes in the state of Maine.

# Part-One

## Overview of Medical Coding and Billing Between Provider and Payer

Medical coding and billing are the process of identifying medical diagnoses, tests, treatments, and procedures found in the clinical documentation for patients and then transcribing this information into standardized codes and then into standardized claims forms to bill government and commercial payers for payment. There are over 10,000 codes used in the coding and billing process that describe medical procedures and services provided to a patient. This process is an intricate and complex system, and although there are national standards and guidelines from the Centers for Medicare and Medicaid Services (CMS), there are differences in how these standards and guidelines are applied in the private sector (commercial insurance companies) primarily based on differences in commercial payer policies.

The UB-04 standardized claim form is used by **institutional** providers for the billing of claims generated for work performed in hospitals, skilled nursing facilities, and other institutions for outpatient and inpatient services, including physicians' fees, the use of equipment and supplies, laboratory services, radiology services, and other charges. (Note: this is the claim form CMS requires for the submission of charges under Medicare Part A, often referred to as hospital insurance)

The CMS-1500 standardized claim form is used by **non-institutional** providers for the billing of claims generated for work performed by physicians, suppliers, and other non-institutional providers for both outpatient and inpatient services. (Note: this is the claim form CMS requires for the submission of charges under Medicare Part B, often referred to as medical insurance). A CMS-1500 may also include a technical component, indicated as a specific Procedure Modifier, to account for the cost of equipment, supplies, and/or technical personnel associated with a service.

Both the UB-04 and the CMS-1500 standardized claim forms contain many of the same data elements and information, including patient demographics, provider identification, identification of procedures and associated charges, and insurance provider. There are however unique data elements in the UB-04 that are not present in the CMS-1500 form and vice versa. These differences allow MHDO to report on payments made by payers to institutional providers (often referred to as facility fees) and payments made to non-institutional providers (often referred to as professional fees).

## Overview of Billing Between Provider and Patient

When a patient visits a provider's office, the billing process typically involves several steps, and the number of bills a patient receives can vary based on several factors. These factors can include the number and types of services received during the visit, the location and type of health care setting the patient visits (hospital, non-hospital) and the ownership (affiliated with a hospital system or unaffiliated), the patient's insurance coverage, and the billing practices and policies of the health care provider and payer. Below is a general overview of the billing process:

1. Service Documentation: The documentation of the services provided to the patient during the visit. This includes the medical exam, tests, procedures, and any other health care services.

2. Insurance Coverage: If the patient has health insurance, the provider will verify the coverage, including what is covered under the patient's plan.

3. Claims Submission: The health care provider submits a claim to the patient's insurance for the services rendered, and depending on the service provider, setting, and insurance type the claim form used is a CMS-1500 or a UB-04 or both. The claim includes details about the patient, services, and associated costs.

4. Insurance Adjudication: The insurance company reviews the claim and determines the amount it will pay based on the patient's coverage. The insurance company will send the patient an Explanation of Benefits, which includes details about how a service was covered, what their plan paid, and the patient's cost share responsibility.

5. Patient Billing: If there is a remaining balance after insurance coverage, the health care provider(s) send a bill to the patient. A patient may receive multiple bills or statements throughout this process, especially if both a CMS-1500 and a UB-04 claim form are used to bill for services rendered during the visit.

# Part-Two

## The Data

For this first report, MHDO is leveraging the information reported in our health care cost and quality website, CompareMaine, the State of Maine's health care transparency website that helps consumers understand the average cost and quality of health care services. The cost data presented on CompareMaine represents Commercial medical claims data only (data from public payers are not included on CompareMaine or in this report) submitted by Commercial Insurance Companies to MHDO. The costs are calculated as total estimated payments, displayed as the average dollar amount the insurance company and the insured pay the provider for a health care service or procedure. Additionally, the average payment data is broken down by facility and professional payments. CompareMaine shows that there is variation in the average payments across health care settings, geography, and by payer for health care procedures.

The structure, form, content and reporting frequency of the health care claims data submitted to MHDO from commercial payers, used to support CompareMaine and this analysis, is defined in 90-590 Chapter 243, *Uniform Reporting System for Health Care Claims Data Sets*. The claims data MHDO collects per these requirements is considered administrative data and mostly aligns with national billing and reporting standards.

The screenshot below is from Appendix D-2 in Chapter 243, which provides the payer with the instructions for creating the MHDO claims data files based on national billing standards. The table identifies the specific data element number, the data element name, a column for where in the UB-04 and CMS-1500 standardized claim forms the data element can be located. This structure allows MHDO to identify in the claims data what is billed on a UB-04 versus a CMS-1500 claim form. Specifically, a claim that is generated on a UB-04 form is identified based on the presence of a populated MC036 Type of Bill and/or MC054 Revenue Code field, as these fields do not exist on a CMS-1500 form.

**Appendix D-2**
**Maine Health Data Organization**
**Medical Claims File Mapping to National Standards**

| Data Element # | Data Element Name | UB-04 Form Locator | CMS 1500 # | HIPAA Reference ASC X12N/005010A1 Transaction Set/Loop/ Segment ID/Code Value/ Reference Designator |
|---|---|---|---|---|
| MC035 | Placeholder | N/A | N/A | N/A |
| MC036 | Type of Bill – Institutional | 4 | N/A | 837/2300/CLM/05-1 |
| MC037 | Place of Service - Professional | N/A | 24B | 837/2300/CLM/05-1 |
| MC038 | Claim Status | N/A | N/A | 835/2100/CLP/02 |
| MC039 | Admitting Diagnosis | 69 | N/A | 837/2300/HI/BJ/01-2 |
| MC040 | E-Code | 72 | N/A | 837/2300/HI/BN/01-2 |
| MC041 | Principal Diagnosis | 67 | 21.1 | 837/2300/HI/BK/01-2 |
| MC042 | Other Diagnosis – 1 | 67A | 21.2 | 837/2300/HI/BF/01-2 |
| MC043 | Other Diagnosis - 2 | 67B | 21.3 | 837/2300/HI/BF/02-2 |
| MC044 | Other Diagnosis - 3 | 67C | 21.4 | 837/2300/HI/BF/03-2 |
| MC045 | Other Diagnosis - 4 | 67D | N/A | 837/2300/HI/BF/04-2 |
| MC046 | Other Diagnosis - 5 | 67E | N/A | 837/2300/HI/BF/05-2 |
| MC047 | Other Diagnosis - 6 | 67F | N/A | 837/2300/HI/BF/06-2 |
| MC048 | Other Diagnosis - 7 | 67G | N/A | 837/2300/HI/BF/07-2 |
| MC049 | Other Diagnosis - 8 | 67H | N/A | 837/2300/HI/BF/08-2 |
| MC050 | Other Diagnosis - 9 | 67I | N/A | 837/2300/HI/BF/09-2 |
| MC051 | Other Diagnosis -10 | 67J | N/A | 837/2300/HI/BF/10-2 |
| MC052 | Other Diagnosis -11 | 67K | N/A | 837/2300/HI/BF/11-2 |
| MC053 | Other Diagnosis -12 | 67L | N/A | 837/2300/HI/BF/12-2 |
| MC054 | Revenue Code | 42 | N/A | 835/2110/SVC/NU/01-2, 835/2110/SVC/04 |
| MC055 | Procedure Code | 44 | 24D | 835/2110/SVC/HC/01-2, 835/2110/SVC/HP/01-2 |
| MC056 | Procedure Modifier - 1 | 44 | 24D | 835/2110/SVC/HC/01-3 |
| MC057 | Procedure Modifier - 2 | 44 | 24D | 835/2110/SVC/HC/01-4 |

## The Analysis

MHDO created a detailed data set of over 100,000 data points leveraging the information reported in CompareMaine – available here. The data set consist of 111 health care procedures displayed by health care providers with a breakdown of the percentage of claims paid on a CMS-1500 (non-institutional) and claims paid on a UB-04 (institutional) for each of the Top 5 commercial payers in Maine, which include: Aetna, Anthem, Cigna Healthcare, Community Health Options, Harvard Pilgrim Health Care. The procedures were organized in the following procedure categories:

| Procedure Category[1] | Number of CPT Codes |
|---|---|
| **Office Visits** | 24 |
| **Behavioral Health Services** | 15 |
| **Outpatient Services** | 8 |
| **Radiology & Imaging** | 64 |
| **Total** | 111 |

Each provider associated with the 111 procedures was organized into two different categories – ownership and health care setting type. Ownership indicates whether the provider is affiliated or unaffiliated with a hospital or a health system based on data reported to MHDO per the requirements of 90-590 Chapter 300. The health care setting type identifies if the provider is a hospital, critical access hospital, or a non-hospital.

[1] Detailed information on the methodology on how costs are calculated can be found on CompareMaine.

| Category | Number of Providers |
|---|---|
| **Ownership** | |
| Affiliated with a Hospital or Hospital System | 82 |
| Unaffiliated | 74 |
| **Setting Type** | |
| Hospital – Critical Access | 16 |
| Hospital – Not Critical Access | 18 |
| Non-Hospital | 122 |
| **Total** | 218 |

Below are a few observations from the detailed data set.

- There are similarities in the percentage of claim payments reported on the CMS-1500 and/or UB-04 for specific procedures and in specific health care settings across the top 5 commercial payers; but there are also differences amongst these payers.
    - An example where the percentage of claims reported on a UB-04 varied was psychiatric diagnosis evaluations (CPT Code: 90791). Critical access hospitals rarely paid on a UB-04 and had a median cost of $149.12 across payers, other hospitals paid on a UB-04 almost 25% of the time and had a higher median payment of $165.
        - When looking at these hospitals by payers, those paying a lower percentage on a UB-04 had lower median payments: Harvard Pilgrim paid 11.25% on a UB-04 with a median payment of $149.12; Aetna paid 40.82% on a UB-04 with a median payment of $221.70; and Community Health Options paid 70.20% on a UB-04 with a median payment of $332.75.
- Office visits were consistently paid on a CMS-1500, but even for instances where there were payments on a UB-04 it did not result in higher median costs. Outpatient procedures consistently billed using UB-04 across payers more than other procedures categories.
- The health care setting type associated with the lowest median payments varied by procedure and payer, but largely occurred in unaffiliated, non-hospital health care settings. This was the case for most outpatient services, behavioral health services, and radiology and imaging services. This was not the case for office visits: the lowest median in office visit costs largely occurred in the Hospital - critical access (CA) setting.
- There are three types of telehealth visits in the office visit category included in this analysis, representing 79 providers (49 Affiliated providers, 30 Unaffiliated providers). Most of these visits were billed exclusively on a CMS-1500. None of the Top 5 insurers paid unaffiliated providers on a UB-04. There were less than ten affiliated providers who billed exclusively on a UB-04 and approximately five providers who billed on both a UB-04 and a CMS-1500.
- The procedures in the office visit and radiology categories provided by an affiliated provider were more likely to have payments paid on both a UB-04 and a CMS-1500. Unaffiliated providers providing office visit and radiology services were more likely to be exclusively paid on

a CMS-1500. Hospital settings provided more radiology services, but the lowest median cost was consistently in the unaffiliated, non-hospital health care setting across payers.

To further illustrate what appears in MHDO's claims data, Table 1 provides detailed information on six procedures in the detailed data set. Here are a few observations:

- Colonoscopies with biopsy (CPT Code: 45380) is one procedure which unaffiliated, non-hospital health care settings did use a UB-04, however with a lower percentage of the total payment from the UB-04 than affiliated settings. Median payments were less overall in the unaffiliated, non-hospital health care settings.

- Some median payments were similar across providers, likely due to the volume of payments that were the same amount. Psychotherapy (CPT Code: 90837) provides an example of this and is an area that could be further explored for examples of standardization across providers and payers.

- Hospital settings completed more MRIs of joint lower extremity without contrast material (CPT Code: 73721) than unaffiliated, non-hospital health care settings, and unaffiliated, non-hospital health care settings largely had the lowest median payment for these procedures.

- The radiology procedure diagnostic mammogram (CPT Code: 77066) provides an example of how procedures may have similar costs, even if the percentage billed between UB-04 and CMS-1500 was substantially different.

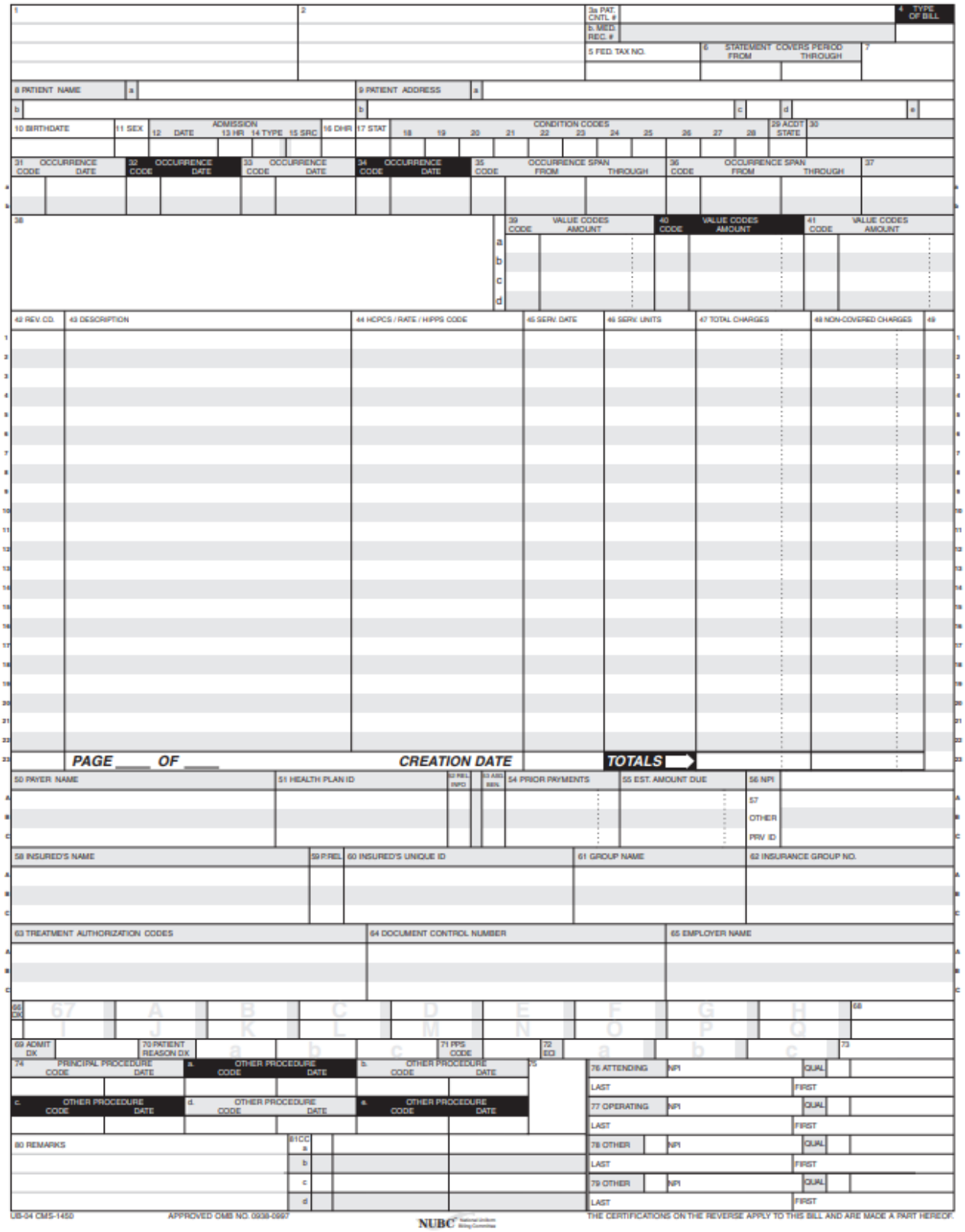
*Table 1 Details for Six Procedures – Percentage of claims paid on a CMS 1500 vs a UB-04, Number of Episodes, and Median Payments*

| Category | Procedure | Affiliated vs. Unaffiliated | Health Care Setting Type | Total (All Payers) | | | |
|---|---|---|---|---|---|---|---|
| | | | | *Number of Episodes* | *% Payment CMS-1500* | *% Payment UB-04* | *Median Payment* |
| **Office Visits** | **CPT Code: 99213-Established patient for low to moderate problems** | **All** | **All** | **245,372** | **98.27%** | **1.73%** | **$ 112.93** |
| | | Affiliated | Hospital | 119,521 | 97.41% | 2.59% | $ 105.86 |
| | | Affiliated | Hospital - CA | 14,774 | 90.58% | 9.42% | $ 86.59 |
| | | Affiliated | Non-hospital | 32,731 | 99.14% | 0.86% | $ 125.75 |
| | | Unaffiliated | Non-hospital | 78,715 | 99.98% | 0.02% | $ 128.04 |
| | **CPT Code: 99442-Physician telephone patient service, 11 to 20 minutes of medical discussion** | **All** | **All** | **1,364** | **96.28%** | **3.72%** | **$ 69.43** |
| | | Affiliated | Hospital | 691 | 96.50% | 3.50% | $ 62.83 |
| | | Affiliated | Hospital - CA | 133 | 66.42% | 33.58% | $ 64.34 |
| | | Affiliated | Non-hospital | 97 | 96.56% | 3.44% | $ 149.15 |
| | | Unaffiliated | Non-hospital | 445 | 100.00% | 0.00% | $ 72.90 |
| **Outpatient Visits** | **CPT Code: 45380-Colonoscopy with biopsy for benign neoplasm** | **All** | **All** | **3,786** | **11.99%** | **88.01%** | **$ 2,387.10** |
| | | Affiliated | Hospital | 2,442 | 9.94% | 90.06% | $ 3,467.45 |
| | | Affiliated | Hospital - CA | 579 | 11.72% | 88.28% | $ 1,809.39 |
| | | Affiliated | Non-hospital | 18 | 5.67% | 94.33% | $ 3,103.10 |
| | | Unaffiliated | Non-hospital | 760 | 28.94% | 71.06% | $ 1,386.40 |
| **Behavioral Health Visits** | **CPT Code: 90837-Psychotherapy, 60 minutes with patient and/or family member** | **All** | **All** | **49,069** | **95.40%** | **4.59%** | **$ 114.34** |
| | | Affiliated | Hospital | 8,614 | 81.64% | 18.36% | $ 114.34 |
| | | Affiliated | Hospital - CA | 1,722 | 96.84% | 3.09% | $ 114.34 |
| | | Affiliated | Non-hospital | 3,547 | 99.03% | 0.97% | $ 147.94 |
| | | Unaffiliated | Non-hospital | 35,365 | 99.91% | 0.09% | $ 114.34 |
| **Radiology Visits** | **CPT Code: 73721-MRI of joint lower extremity without contrast material** | **All** | **All** | **2,108** | **32.35%** | **67.65%** | **$ 1,122.18** |
| | | Affiliated | Hospital | 969 | 10.80% | 89.20% | $ 1,215.17 |
| | | Affiliated | Hospital - CA | 359 | 6.28% | 93.72% | $ 1,812.37 |
| | | Affiliated | Non-hospital | 63 | 6.61% | 93.39% | $ 1,820.39 |
| | | Unaffiliated | Non-hospital | 776 | 99.83% | 0.17% | $ 933.03 |
| | **CPT Code: 77066-Diagnostic mammogram, including computer-aided detection, both breasts** | **All** | **All** | **2,989** | **28.98%** | **71.02%** | **$ 454.10** |
| | | Affiliated | Hospital | 2,040 | 16.55% | 83.45% | $ 504.22 |
| | | Affiliated | Hospital - CA | 446 | 17.76% | 82.24% | $ 404.93 |
| | | Affiliated | Non-hospital | 53 | 14.91% | 85.09% | $ 503.37 |
| | | Unaffiliated | Non-hospital | 500 | 99.22% | 0.78% | $ 417.20 |

## Next Steps

As noted above, there are thousands of data points that support this first annual report that have been organized into an excel spreadsheet. There are other data in MHDO's commercial claims data that support the summary level data. The full scope of data collected by MHDO may support specific follow up questions that the Health Coverage, Insurance and Financial Services Committee and/or the Office of Affordable Health Care may have regarding the billing and payment transactions between the provider and the payer. Because MHDO leveraged existing data sets in the creation of the contents in the excel spreadsheet, the information is specific to commercial payers only and does not include data for public payers (MaineCare and Medicare). As noted above there are coding and billing standards and guidelines established by the Centers for Medicare and Medicaid Services (CMS) that may differ from the policies of the commercial market. What appears to be universal across the different payer categories is the use of the standardized claim forms (UB-04 and the CMS-1500). MHDO has the data to analyze the billing and payment transactions that occur between the provider and the public payers. However, this analysis will take more time as MHDO does not have the existing infrastructure built for the public payers. To structure the data for the public payers in the same way as the commercial payers, MHDO may require additional resources.

# Appendix A: UB-04



**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).**

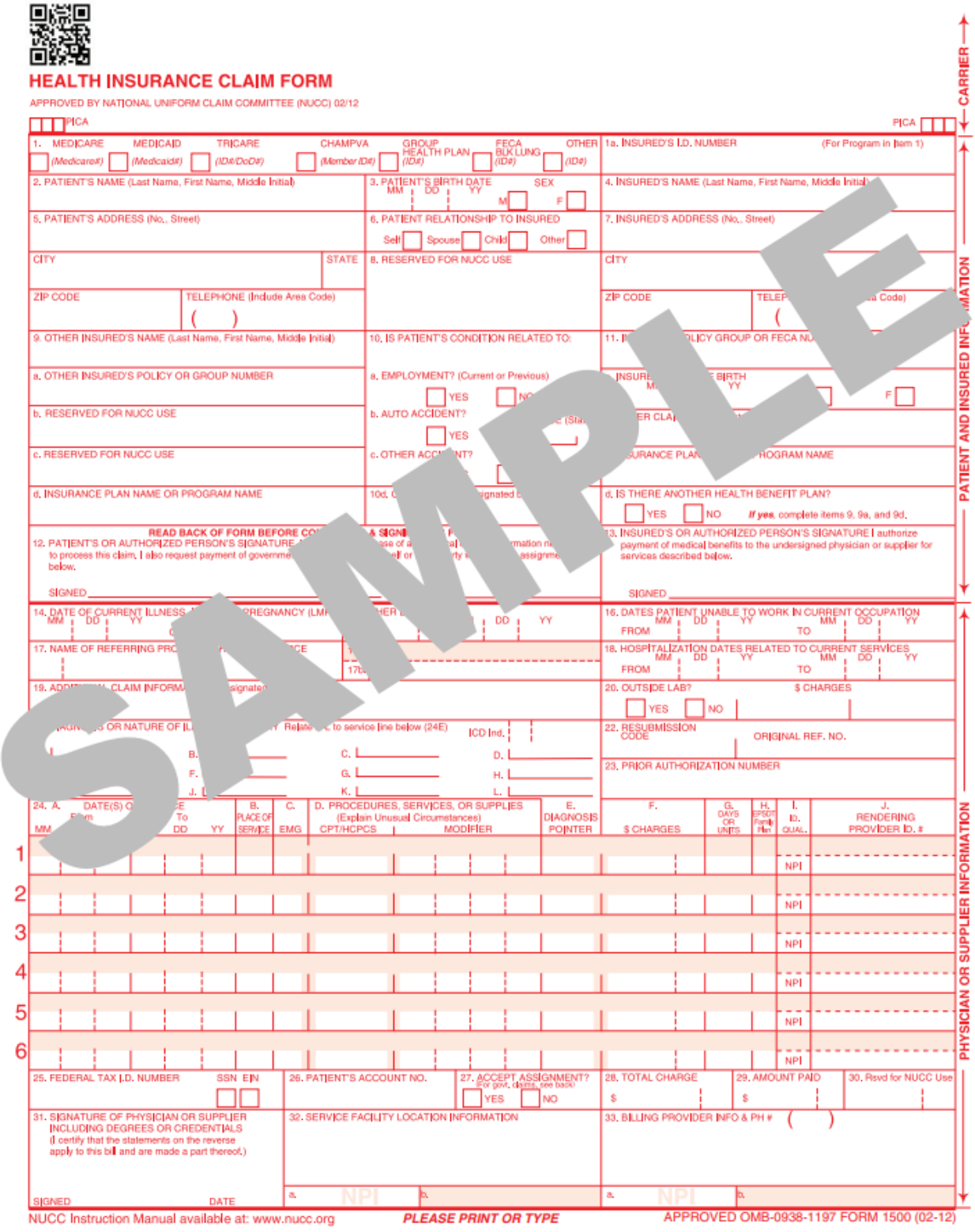
Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where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

SEE http://www.nubc.org/ FOR MORE INFORMATION ON UB-04 DATA ELEMENT AND PRINTING SPECIFICATIONS

Source: ub-40-P.pdf (cdc.gov)

# Appendix B: CMS-1500



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. Designated by NUCC

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY

15. OTHER DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. F. G. H. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | NPI | |
| 2 | | | | | | | | | NPI | |
| 3 | | | | | | | | | NPI | |
| 4 | | | | | | | | | NPI | |
| 5 | | | | | | | | | NPI | |
| 6 | | | | | | | | | NPI | |

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

**REFERS TO GOVERNMENT PROGRAMS ONLY**

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

**BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

**SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)**

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (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, carriers, intermediaries, 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, 'Carrier Medicare Claims Record,' 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.

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

Source: [Health Insurance Claim form (cms.gov)]