DHS
Oregon Department
of Human Services

UB-04
Billing Instructions

Division of Medical Assistance Programs
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Introduction

The *UB-04 Billing Instructions* handbook is designed to help those who bill the Department's Division of Medical Assistance Programs (DMAP) for Medicaid services complete the billing form correctly the first time. This will give you step-by-step instructions so that DMAP can pay you, the provider, more quickly. Use this handbook with the General Rules and your provider guidelines (administrative rules and supplemental information), which contain information on policy and covered services specific to your provider type.

This handbook lists the requirements for completion prior to sending your claim to DMAP for payment processing, as well as helpful hints on how to avoid common billing errors.

The *UB-04 Billing Instructions* are designed to assist institutional providers who bill DMAP for Medicaid services:*

- Freestanding kidney dialysis centers
- Home health agencies
- Hospice services
- Hospitals

*If in doubt of which claim form to use, contact DMAP Provider Services at 800-336-6016 for assistance, or refer to your provider guidelines.

Claims Processing

The federal government requires DMAP to process Medicaid claims through an automated claim processing system known as MMIS - the Medicaid Management Information System. This system is a combination of people and computers working together to process claims.

Paper claims submitted by mail go first to the DHS Office of Document Management (ODM) Imaging Unit.

- The document is scanned through an Optical Character Recognition (OCR) machine and the claim is given an Internal Control Number (ICN). The scanner converts 2,500 to 3,000 documents per hour into images.
- The scanned documents are then identified and sorted by form type and indexed by identifiers such as client name, prime identification number, the date of service, and provider number.
- Finally, the data and images are stored on an Electronic Document Management System (EDMS) which staff access via the DHS intranet.

Once the claim is scanned through the Optical Character Reader, staff can immediately access submitted claim information by checking certain MMIS screens. The system processes most paper claims within 30 days. The fewer questions the computer asks, the more quickly it can process the claim.

The system performs daily edits for presence and validity of data. Once a week, the system audits all claims to ensure that they conform to medical policy. Every weekend, a payment cycle runs, and the system produces checks for claims that successfully pass all edits and audits.

DMAP staff members will see the claim only if MMIS cannot make a payment decision based on the information submitted. The system directs the claim to DMAP staff for specific medical or administrative review. This type of claim is a *suspense (suspended) claim*.

DMAP does not return denied claims to providers. Instead, DMAP mails a listing of all claims paid and/or denied to the provider (with payment if appropriate). The listing is called a Remittance Advice (RA).

Uniform Billing (UB) Claim Form

DMAP does not supply this form. This form is available through local business forms suppliers, or by calling the Standard Register Company, Forms Division at 800-755-6405.

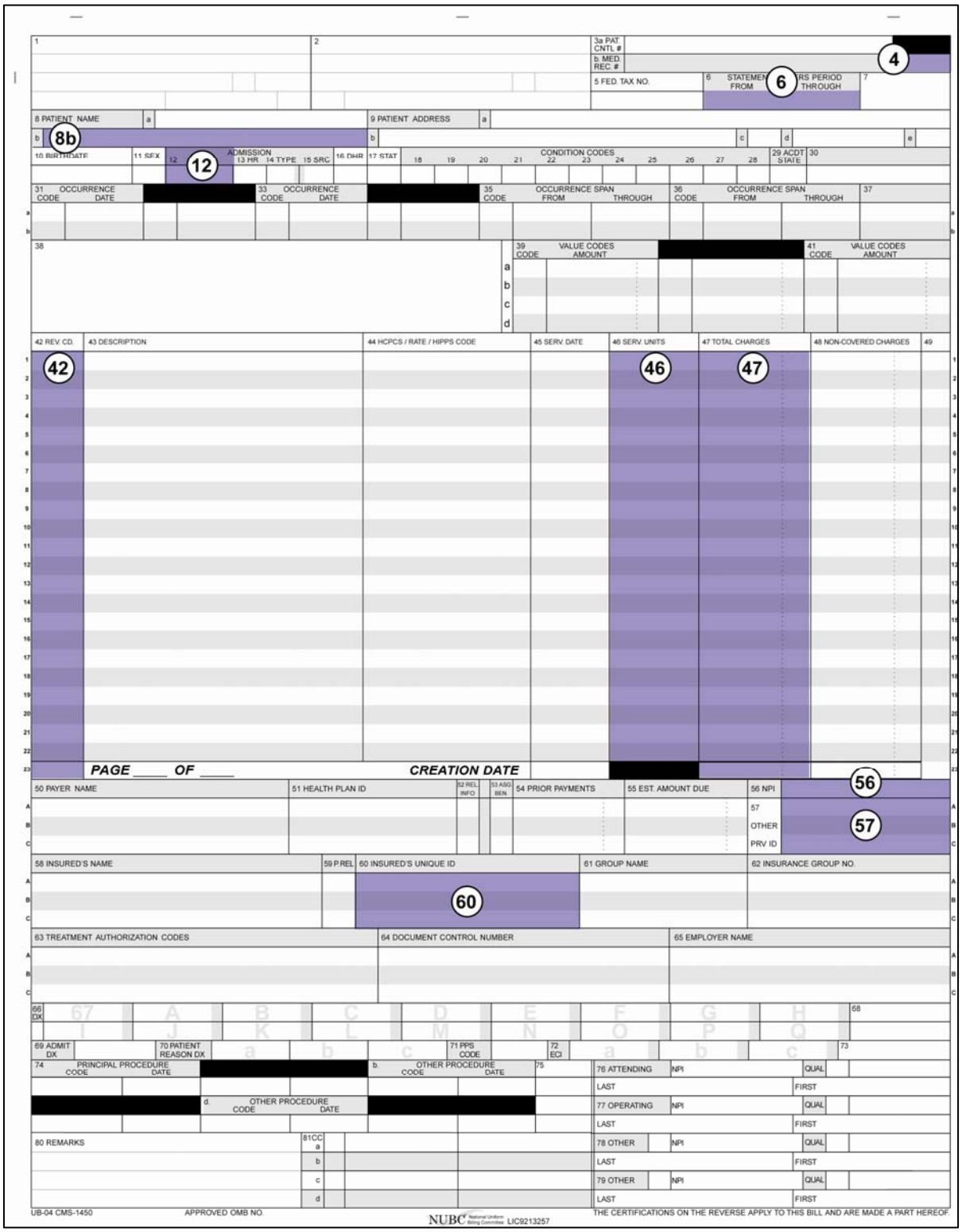
Valid claim formats

DMAP only accepts the UB-04 claim form. We will return claims submitted on the UB-92 form with a request to resubmit the claim on the correct form.

DMAP processes hardcopy claims using Optical Character Recognition (OCR) scanning. Make sure your claim forms meet OCR specifications. If your forms are not to scale, or if the fields on your form are not correctly aligned, DMAP will manually enter your claim, which may delay processing of the claim.

UB-04 Claim Form

The fields on the UB claim form are called Field Locators (FL). Shaded boxes are fields DMAP uses to process your claim; your claim may suspend or deny if information in this box is missing or incomplete.



Required Field Locators

Shaded boxes are always mandatory. Non-shaded boxes are mandatory if applicable.

Box	FL	Description
3a	**Patient Control No.**	If a patient account number is provided in this box, DMAP will print it on the Remittance Advice (RA).
4	**Type of Bill**	**Enter the appropriate three (3)-digit code that identifies the type of service you are billing for.** See the "Type of Bill Codes" section of the *Appendix* for specific codes by provider type, or refer to the provider guidelines for your program.
6	**Statement Covers Period**	**Enter the beginning and ending dates of service covered by this claim.** Use MMDDYY numeric format (example: 102806). Total days in this field must correspond to the number of units in FL 46. • "From" date is the date services began. • "Through" date is the date services ended.
8b	**Patient Name**	**Enter the recipient name exactly as it is printed on the Medical Care Identification.** DO NOT use "nicknames".
12	**Admission Date**	**Enter the actual admission date.** Use MMDDYYYY format.
13	**Admission Hour**	**For inpatient and outpatient hospital services, enter the hour of admission.** Use numbers from 00 to 24 (01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m. 23 = 11 p.m., etc.).
14	**Type of Admission or Service**	**For inpatient hospital services, enter the one (1)-digit code to indicate type of service.** Use one of the following codes (see OAR 410-125-0401 for definitions): • **1 -** Emergent • **2 –** Urgent • **3 –** Elective • **4 -** Newborn
16	**Discharge Hour**	**For inpatient and outpatient hospital services, enter the hour of discharge.** Use numbers from 00 to 24 (01 = 1 a.m., 10 = 10 a.m., 13 = 1 p.m. 23 = 11 p.m., etc.).

Box	FL	Description
17	**Patient Status**	**For inpatient hospital services, enter the two (2)-digit code to indicate patient status at time of discharge.** See *Appendix* for a list of codes.
42	**Revenue Codes**	**Enter the four (4)-digit code that most accurately describes the service provided.** For a complete list of Revenue Center Codes for your provider type, refer to your program's Supplemental Information handbook. **Enter "0001" in line 23 of this field** to indicate the claim's total charges (entered in FL 47).
44	**HCPCS/Rates**	**Enter the five (5)-digit code for each Revenue Center Code requiring CPT/HCPCS.** Refer to the "Revenue Center Code Table" or rate information in your program's Supplemental Information handbook for revenue codes requiring CPT/HCPCS. • Inpatient hospital services do not require CPT/HCPCS.
46	**Service Units**	**Enter total days or units of service for each Revenue Center Code listed.** • One visit equals one unit of service. • One supply item equals one unit of service.
47	**Total Charges**	**Enter the usual and customary charge for each Revenue Center Code listed.** Enter the sum of all charges in line 23 of this field.
50	**Payer Identification**	**Enter the name(s) of the payer organizations you are billing (up to three payers).** • If DMAP is the only payer, enter DMAP/Medicaid on Line A. • DMAP is the payer of last resort. Any resources billed prior to billing DMAP should be listed first.

Box	FL	Description
54	**Prior Payments**	**Enter the actual amount of any payments you received from Third Party Resources (TPR).** Use the line that corresponds to the line used for DMAP in FL 50. • If Medicare paid, show the actual Medicare payment. • Do not list write-offs, what Medicaid previously paid, or copayments.
56	**NPI**	**Enter your ten (10)-digit National Provider Identifier.**
57	**Other Provider ID**	**Enter your six (6)-digit DMAP provider number on the line that corresponds to the line used for DMAP in FL 50.** DMAP will pay this provider.
60	**Insured's Unique ID**	**Enter the eight (8)-digit Medicaid Prime Identification Number.** Use the line that corresponds to the line used for DMAP in FL 50. • The prime number is printed on the Medical Care Identification, or you can obtain it through the Automated Information System Plus (AIS Plus) at 800-522-2508.
63	**Treatment Authorization Codes**	**If the service was prior authorized, enter the nine (9)-digit Prior Authorization number that DHS issued for the service.** Use the line that corresponds to the line used for DMAP in FL 50. • For all services **except** inpatient hospital: DO NOT bill prior-authorized and non-authorized services on the same claim form. You must submit separate UB claim forms. • Bill all inpatient hospital services (both prior-authorized and non-authorized) on a single claim.
67	**Principal Diagnosis Code**	**Enter the primary diagnosis/condition of the recipient by entering the current ICD-9-CM code.** The diagnosis code must be the reason chiefly responsible for the service being provided as shown in the medical records. • Carry out code to its highest degree of specificity. • DO NOT enter the decimal point.

Box	FL	Description
67A – 67D	**Other Diagnosis Codes**	**Enter up to four (4) additional ICD-9-CM codes, as appropriate.** You can enter additional diagnosis codes for conditions that: • Coexist at the time of admission. • Develop subsequently. • Affect treatment received and/or length of treatment.
78	**Other Physician ID**	**For Primary Care Manager (PCO) or Physician Care Organization (PCO) clients, list the ten (10)-digit NPI, followed by the six (6)-digit DMAP provider number of the PCM/PCO.**
80	**Remarks**	**If the recipient has other medical coverage, enter the appropriate two (2)-digit third party resource (TPR) explanation code.** See *Appendix* for TPR explanation codes.

Helpful Tips

Additional information is available on DMAP's Web site at www.oregon.gov/DHS/healthplan. Click on "Tools for Providers," then "Billing Tips."

READ your provider guidelines! Pay special attention to the billing instructions. Be sure you have the most current rulebook and supplemental information that are in effect for the date of service you are billing for.

- Provider guidelines are available at DMAP's Web site. Click on "Tools for Providers," then "Policies." Click "more" for a list of current guideline pages.
- If you do not have internet access, you may contact DMAP at 800-527-5772 and ask to have provider guidelines mailed to you.

VERIFY patient eligibility on the date of service. The date of service is that date you provided the service. If possible, photocopy the Medical Care ID and/or verify with one of the electronic eligibility verification services listed on DMAP's Electronic Eligibility Verification Web page at www.oregon.gov/DHS/healthplan/tools_prov/electronverify.shtml.

- **Automated Information System (AIS) by phone:** Call 800-522-2508;
- **AIS Plus on the internet:** Go to the Electronic Eligibility Verification Web page, then click "AIS" to register for Web-based access;
- **Electronic Eligibility Verification Service (EEVS) Vendor**: Go to the Electronic Eligibility Web page, or call 800-336-6016 for a copy of the vendor list.

The patient name and number on the UB claim form must match the name and number shown on the patient's Medical Care Identification (ID). A Medical Care ID number is always eight characters and shows in Box 6 of the Medical Care ID. The General Rules supplemental information book shows an example of a Medical Care ID.

BEFORE billing DMAP…

- **MAKE SURE** that you billed prior resources and reported the correct dollar amount in FL 54.
- **DO NOT** attach prior resource EOB's.
- **ALWAYS USE** the correct 2-digit third party resource (TPR) explanation code in the Remarks field when the client has TPR. If the client has TPR, you must enter the appropriate code even when the TPR made no payment. Always enter a code if the client has more than one TPR available.

USE commercially available "red form" versions of the UB-04 (not black and white copies) whenever possible. When you submit your claims on "red forms," Optical Character Recognition (OCR) technology scans the claim data directly into the claims processing system. OCR technology increases the accuracy and efficiency of claims processing, but cannot be used on black and white claim forms.

USE only one prior authorization number in FL 63. Unless you are billing for inpatient hospital services, DO NOT bill authorized services and services that do not require authorization on the same claim form.

ALWAYS ENTER the DMAP 6-digit provider number you want DMAP to send payment to in FL 57. It is crucial that you list this information. An invalid or missing provider number could delay your payment, make payment to a wrong provider or deny your payment.

CHECK your claim form for legibility so that we can clearly read it. Avoid tiny print, print that overlaps onto a line, entering more than 22 lines per claim, and poorly handwritten claim forms. Complete only the required boxes.

EACH UB-04 is a complete billing document. DO NOT carry over totals from one UB claim form to the other.

- For inpatient hospital services, you must bill all procedures provided **on the same date of service** on a single claim.
- For all other services billed on the UB, if there is not enough space available on the UB claim form to bill all procedures provided **on the same date of service**, complete a new billing form for the rest of the procedures.

READ the explanation of benefit (EOB) codes on your Remittance Advice. They will tell you what the error is, and if you should re-bill or submit an Individual Adjustment Request form (DMAP 1036).

CONTACT Provider Services at 800-336-6016 for assistance in completing your UB-04 or other questions regarding an institutional claim.

Appendix

Type of Bill Codes

Use in Field Locator (FL) 4 of the UB-04. DMAP accepts the following codes:

Home Health Services

321	Admit through Discharge Claim: Encompasses an entire home health span of service for which the agency expects reimbursement.
322	First Claim: Use for the first of an expected series of payment claims for the same home health start of care.
323	Interim-Continuing Claim: Use when one or more claims for the same home health start of care have already been submitted, and further claims are expected to be submitted at a later date.
324	Interim-Last Claim: Use for a claim which is the last of a series for a home health start of care. The "through" date of this claim (FL 6) is the discharge date or date of death for this service span.

Hospice Services

Codes beginning in "81" indicate non-hospital based hospice services; codes beginning in "82" indicate hospital-based hospice services.

811	**821**	Admit through Discharge Claim: Encompasses an entire course of hospice treatment. Use when no further bills will be submitted for this client (*i.e.*, client revokes or expires within the first billing period).
812	**822**	First Claim: Use this code for the first of an expected series of payment bills for course of treatment.
813	**823**	Interim-Continuing Claim: Use when a bill has been submitted and further bills area expected to be submitted.
814	**824**	Last Claim: Use for a bill which is the last of a series for a hospice course of treatment. The through date of this bill (FL 6) is the discharge date or date of death.

Hospital Services – Inpatient

111	Use for most inpatient billings, including patients with Medicare Part A coverage only.
121	Use for patients with Medicare Part B coverage only.

Hospital Services – Outpatient

131	Use for most outpatient billings.
141	Referenced Diagnostic Services
831	Hospital-based ambulatory surgery

Kidney Dialysis Services

721	Independent End Stage Renal Dialysis Facilities

Patient Status Codes

This information is required for inpatient hospital claims only. Use in FL 17 of the UB-04 form.

01	Discharged to home or self care (routine discharge)
02	Discharged or transferred to another acute care hospital
03	Discharged or transferred to skilled nursing facility (SNF)
04	Discharged or transferred to an intermediate care facility (ICF)
05	Discharged or transferred to another type of institution (not another acute care hospital)
06	Discharged or transferred to home under care of home health service organization
07	Left against medical advice
08	Discharged to home under care of Home Enteral/Parenteral Provider
20	Expired

Third Party Resource (TPR) Explanation Codes

Use in FL 80 on the UB-04 form.

Single Insurance Coverage

Use a single insurance code when the client has only one insurance policy in addition to Medicaid.

UD	Service Under Deductible
NC	Service Not Covered by Insurance Policy
PN	Patient Not Covered by Insurance Policy
IC	Insurance Coverage Canceled/Terminated
IL	Insurance Lapsed or Not in Effect on Date of Service
IP	Insurance Payment Went to Policyholder
PP	Insurance Payment Went to Patient
NA	Service Not Authorized or Prior Authorized by Insurance
NE	Service Not Considered Emergency by Insurance
NP	Service Not Provided by Primary Care Provider/Facility
MB	Maximum Benefits Used for Diagnosis/Condition
RI	Requested Information Not Received by Insurance from Patient
RP	Requested Information Not Received by Insurance from Policyholder
MV	Motor Vehicle Accident Fund Maximum Benefits Exhausted
AP	Insurance Mandated Under Administrative/Court Order Through an Absent Parent-and Not Paid Within 30 Days
OT	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

Multiple Insurance Coverage

Use in FL 80 on the UB-04 form. Use a multiple insurance code when the client has more than one insurance policy in addition to Medicaid.

MP	Primary Insurance Paid – Secondary Paid
SU	Primary Insurance Paid – Secondary Under Deductible
MU	Primary and Secondary Under Deductible
PU	Primary Insurance Under Deductible - Secondary Paid
SS	Primary Insurance Paid – Secondary Service Not Covered
SC	Primary Insurance Paid – Secondary Patient Not Covered
ST	Primary Insurance Paid – Secondary Canceled/Terminated
SL	Primary Insurance Paid – Secondary Lapsed or Not in Effect
SP	Primary Insurance Paid – Secondary Payment Went to Patient
SH	Primary Insurance Paid – Secondary Payment Went to Policyholder
SA	Primary Insurance Paid – Secondary Denied - Service Not Authorized
SE	Primary Insurance Paid – Secondary Denied - Service Not Considered Emergency
SF	Primary Insurance Paid – Secondary Denied - Service Not Provided by Primary Care Provider/Facility
SM	Primary Insurance Paid – Secondary Denied - Maximum Benefits Used for Diagnosis/Condition
SI	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Policyholder
SR	Primary Insurance Paid – Secondary Denied - Requested Information Not Received from Patient
MC	Service Not Covered by Primary or Secondary Insurance
MO	Other (if above codes do not apply, include detailed explanation of why no TPR payment was made)

Who to Call for Help

Automated Information System Plus (AIS Plus) To verify eligibility, benefit packages, managed care, primary care manager, limited service information. • Available Monday through Saturday - 3 a.m. to midnight, Sunday - 6 a.m. to 7 p.m.	**800-522-2508**
AIS Technical Help Desk When you need help with AIS Plus. • Available 24 hours a day, 7 days a week.	**800-884-3250**
DMAP Benefit RN Hotline For coverage of diagnosis/treatment pairs. • Available Monday through Friday - 8 a.m. to 5 p.m.	**800-393-9855**
DMAP Claims Management Group For out-of-state claims. • Available Monday through Friday - 8 a.m. to 5 p.m.	**800-527-5772**
DMAP Provider Enrollment Group To enroll/disenroll as a DMAP provider, change of address or other changes to your enrollment. • Available Monday through Friday - 8 a.m. to 5 p.m.	**800-422-5047**
DMAP Provider Services Unit For questions about completing a claim form correctly the first time, billing, electronic claims submission, ordering provider guidelines, supplemental information, or fee schedule. • Available Monday through Friday - 8 a.m. to 5 p.m.	**800-336-6016**