Home Health UB-04

Claim form billing instructions for the Department of Human Services



Overview

This step-by-step presentation is intended to provide information to assist those who bill the Division of Medical Assistance Programs (DMAP) for Medicaid services complete the UB-04 billing form correctly the first time. This presentation is to be used in conjunction with General Rules, your provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~DHS~

MMIS

- The federal government requires DHS to process Medicaid claims through an automated claim processing system known as the Medicaid Management Information System (MMIS).
- This system is a combination of people and computers working together to process claims.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision based on the information submitted.

Claims Processing

- Paper claims submitted by mail go to the DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).

Before you bill

- Read your provider guidelines.
- Verify recipient eligibility on the date of service.
- Make sure you bill all prior resources first. DHS is the payer of last resort.
- Use commercially available "red form" versions of the UB-04.

A few tips!

- When submitting handwritten claim forms, you must use blue or black ink, never use red ink.
- Make sure your hand writing is legible.
- If possible, submit no more than twenty-two lines of services per claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

Form suppliers

- The UB-04 form is not supplied by DHS.
- Forms are available by contacting one of the following:
 - Local business forms suppliers
 - Standard Register Company, Forms Division (800-755-6405)

Services billed on the UB-04

Institutional Providers

- Free Standing Kidney Dialysis
- Home Health
- Hospice
- Hospital

Services billed on the UB-04

- If you are not sure what claim form you are required to use, contact DMAP Provider Services. They can be reached at:
 - Toll free: 800-336-6016
 - E-mail: DMAP.providerservices@state.or.us

Introducing the UB-04



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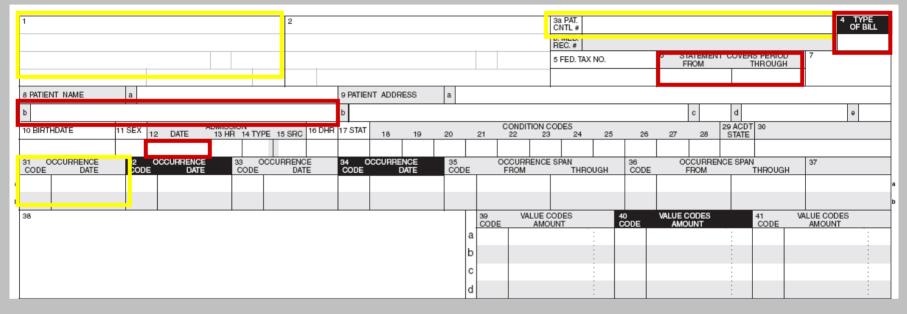
UB-04

• Not sure if you are using the correct form?

The bottom left corner will look like this.

UB-04 CMS-1450

Top section



Red = Required

Yellow = Optional

Box 1 - Optional



Billing Provider Information

 Enter the name and address of the Home Health agency that is requesting to be paid for the services rendered.

Box 3a - Optional

3a PAT. CNTL # X123400

Patient Account Number

- Enter your recipient account number here.
- This box allows up to twelve characters.
- This number will appear on your Remittance Advice (RA).

Box 4 - Required



Type of Bill

- Enter the three-digit numeric code to identify the type of claim you are billing.
 - First-digit: Always use an 3 for Home Health
 - Second-digit: Always use 2 for in-home visits
 - Third-digit: Use 1 for admit through discharge date
 Use 2 for first claim
 Use 3 for interim-continuing claim
 Use 4 for interim-last claim

Box 6 - Required

6	STATEMENT FROM	COVERS PERIOD THROUGH
	040107	040707

Statement Covers Period

- Enter the beginning and ending dates of services covered by this claim.
- This box must list numeric dates of service.

Box 8b - Required



Recipient Name

- Enter the recipient's name exactly as it is printed on the Medical Care Identification.
- Use the recipient's last name first.
- Do not use nicknames.

Box 12 - Required



Admission Date

 Enter the actual admission date, even if the recipient was not eligible on that date.

Box 31 - Optional

31 O	CCURRENCE
CODE	DATE

Accident Occurrence

- If this claim is a result of an accident, enter one of the following codes and the date of the occurrence.
 - 01 Auto accident
 - 04 Employment related accident
- Pursue all prior resources first.
- DMAP is the payer of last resort.

Middle section

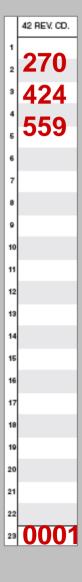
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Red = Required

Box 42 - Required

Revenue Center Codes

- Enter a three-digit revenue center code which most accurately describes the service provided.
- Refer to your Home Health supplemental for a complete list of revenue center codes or on the following page.



Revenue Center Codes

270	General classification
271	Non-sterile supplies
272	Sterile supplies
421	Physical therapy visit charge (payment authorization required)
424	Physical therapy evaluation/reevaluation
431	Occupational therapy visit charge (payment authorization required)
434	Occupational therapy evaluation/reevaluation
441	Speech language pathology visit charge (payment authorization required)
444	Speech language pathology evaluation/reevaluation
	Revenue center codes continued on next slide

Revenue Center Codes

551	Skilled nursing visit charge (payment authorization required)
559	Other skilled nursing evaluation
571	Home health aide visit charge (payment authorization required)
0001	For total claim

Box 44 - Optional



HCPCS Codes

- If applicable, enter a five-character HCPCS for the service provided.
- For "unlisted" codes, you must attach an explanation for manual pricing.
- HCPCS are required for revenue center codes 421, 424, 431, 434, 441 and 444.

Box 45 - Optional

45 SERV. DATE

Service Date

- Enter a date of service for each revenue center code listed.
- Dates must match as indicated in box 6.

Box 46 - Required

Service Units Enter the nur related reven

46 SERV. UNITS

6

7

3

- Enter the number of days or units for each related revenue center code listed.
- One visit equals one unit of service.
- One supply item equals one unit of service.

Box 47 - Required

47 TOTAL CHARGES

22 30

151 00

5700

Total Charges

- Enter the total usual and customary charge for each related revenue center code listed.
- Do not list credits.
- Do not use dashes.

Total - Required



Total

- Enter the total charge amount for all services listed in column 47.
- Each claim form is a separate document, and is to be totaled as such.

Bottom section

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Red = Required

Yellow = Optional

Box 50 - Optional

50 PAYER NAME

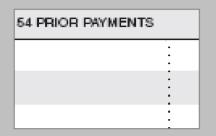
- Primary payer
- Secondary payer
- Tertiary payer

Payer Name

 Enter the names of up to three payer organizations in order.

> Example: If Medicaid is primary, enter on line A. If Medicaid is secondary, enter on line B. If Medicaid is tertiary payer, enter on line C.

Box 54 - Optional



Prior Payments

- Enter the total amount paid by other third party resource's.
- Do not list write-off's.
- Do not include how much DHS previously paid.
- Do not include copayments.
- Correspond the placement as outlined in box 50 instructions.

Box 56 - Required

58 NPI ##########

National Provider Identifier (NPI)

 Enter the ten-digit NPI of the Home Health agency billing for services rendered.

Box 57 - Required

57 OTHER ##### PRV ID

Provider Number

- Enter the six-digit (DHS issued) provider number of the Home Health agency billing for services rendered.
- Do not list other payer provider numbers.
- Correspond the placement number as outlined in box 50 instructions.

Box 60 - Required

60 INSURED'S UNIQUE ID

X X # # # X # X

Recipient ID Number

- Enter the recipient's eight-character prime identification number.
- Enter the number exactly as it appears on the Medical Care Identification.
- Correspond the placement as outlined in box 50 instructions.

Box 63 - Optional

63 TREATMENT AUTHORIZATION CODES

#########

Treatment Authorization

- If the service you provided requires payment authorization (PA), enter the nine-digit payment authorization number that was issued for the service.
- Only use one payment authorization number per claim form.
- Correspond the placement as outlined in box 50 instructions.

Box 66 - Required



Diagnosis Code

- Enter the recipient's diagnosis/condition.
- The diagnosis code must be the reason chiefly responsible for the service being provided as shown in medical records.
- You may enter up to five codes if necessary by listing them in box 67 - 67D.
- The diagnosis codes must be carried out to its highest degree of specificity.
- Do not use the decimal point.

Box 78 - Optional

Referring Provider ID

INFI #1

78 OTHER

 This box is only required when the recipient is referred by their Primary Care Manager (PCM) or Physician Care Organization (PCO).

QUAL

- Enter the ten-digit NPI of the referring PCM or PCO.
- Enter the six-digit (DHS issued) provider number of the referring PCM or PCO.
- If the recipient is not referred by the PCM or PCO, leave this box blank. Rendering provider numbers or sixnines are no longer required.

Box 80 - Optional

80 REMARKS	٦
NC	

Third Party Resource

- If the recipient has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.
- A code must be listed when the other insurance did not make a payment, and always when the recipient has more than one other insurance carrier.
- TPR codes can be found in your specific provider rulebook supplemental, or on the following slides.

Single carrier TPR codes

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
	Single carrier TPR codes continued on next slide

Single carrier TPR codes

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 (MVAF) maximum benefits exhausted
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days
ОТ	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)

Multiple carrier TPR codes

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
	Multiple carrier TPR codes continued on next two slides

Multiple carrier TPR codes

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
	Multiple carrier TPR codes continued on next slide

Multiple carrier TPR codes

SR	Primary insurance paid – secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
МО	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurances)

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Resources



Where to mail your claim

Mail your UB-04 claim form to:

DMAP PO Box 14956 Salem, OR 97309-4957

Who to call if you need help

- Contact DHS' DMAP Provider Services if you need assistance or questions concerning your UB-04 claim form.
- They can be reached at:
 - Toll free: 800-336-6016
 - E-mail: DMAP.providerservices@state.or.us

Thank You!

