Hospital Outpatient "Crossover" UB-04

Claim form billing instructions for the Department of Human Services

DHS
Oregon 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).

About the crossover

- If the recipient has Medicare Part B, you must bill Medicare first.
- Medicare will automatically send your claim to DMAP, this is called a “crossover”.
- Do not submit claims to DMAP until they have been billed to and adjudicated by Medicare.

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 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

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

7	8 PATIENT NAME	9 PATIENT ADDRESS
	a	a
	b	b c d e

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

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

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
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18								18
19								19
20								20
21								21
22								22
23		PAGE ____ OF ____ CREATION DATE			TOTALS			23

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

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

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

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

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

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75

c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

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

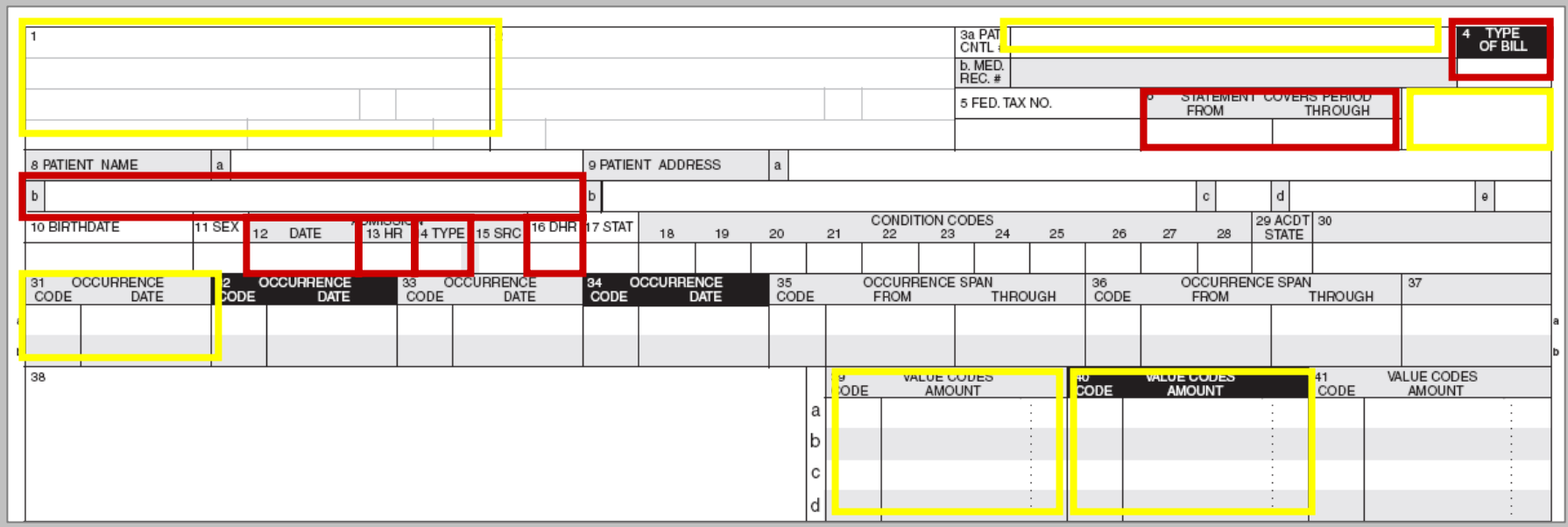
UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-04

- Not sure if you are using the correct form?

The bottom left corner will look like this.

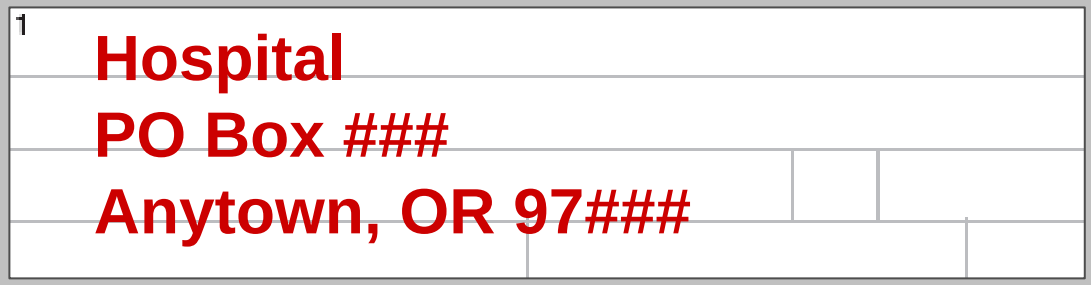
Top section



Red = Required

Yellow = Optional

Box 1 - Optional



Billing Provider Information

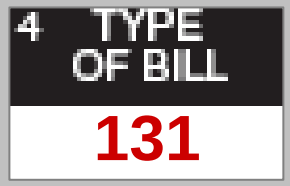
- Enter the name and address of the Hospital that is requesting to be paid for the services rendered.

Box 3a - Optional

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.
  - 131 - Outpatient
  - 141 - Outpatient referenced diagnostic services
  - 721 - Independent End Stage Renal Dialysis Facilities
  - 831 - Hospital Based Ambulatory Surgery

Box 6 - Required

6 STATEMENT COVERS PERIOD FROM	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.
- The from date is the date of admission.
- The through date is the date of discharge, transfer or expiration.

Box 7 - Optional

Crossover

- If the recipient has Medicare Part B, and the service is covered by Medicare, enter “XOVR”.
- Do not enter XOVR if the recipient has Medicare Part A only.

Box 8b - Required

8 PATIENT NAME	a.	
b	Patient, Your	

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 date of admission.
- This date must match the “from” date of service as indicated in box 6.

Box 13 - Required

Admission Hour

- Enter the hour of admission in military time.
- Example:

  01 - 1:00 a.m.

  10 - 10:00 a.m.

  14 - 2:00 p.m.

  23 - 11:00 p.m.

Box 14 - Required

Admission Type

- Enter the type of admission.
- Example:

  1 - Emergent

  2 - Urgent

  3 - Elective

  4 - Newborn

Box 16 - Required

Discharge Hour

- Enter the discharge hour in military time.
- Example:

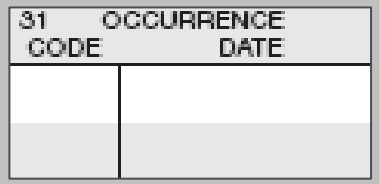
01 - 1:00 a.m.

10 - 10:00 a.m.

14 - 2:00 p.m.

23 - 11:00 p.m.

Box 31 - Optional



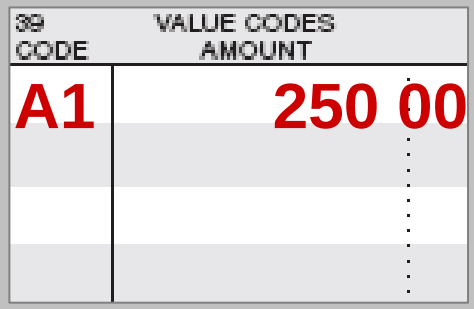
Accident Occurrence

- 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.

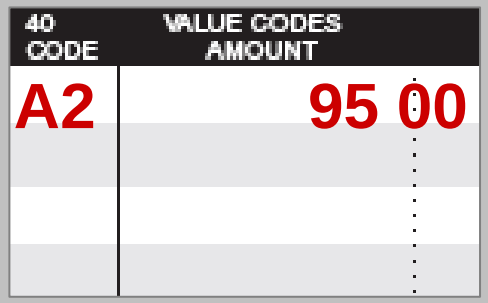
Box 39 - Optional



Value Codes

- Enter value code “A1” to identify Medicare Part B deductible.
- Enter Medicare Part B deductible dollar amount.

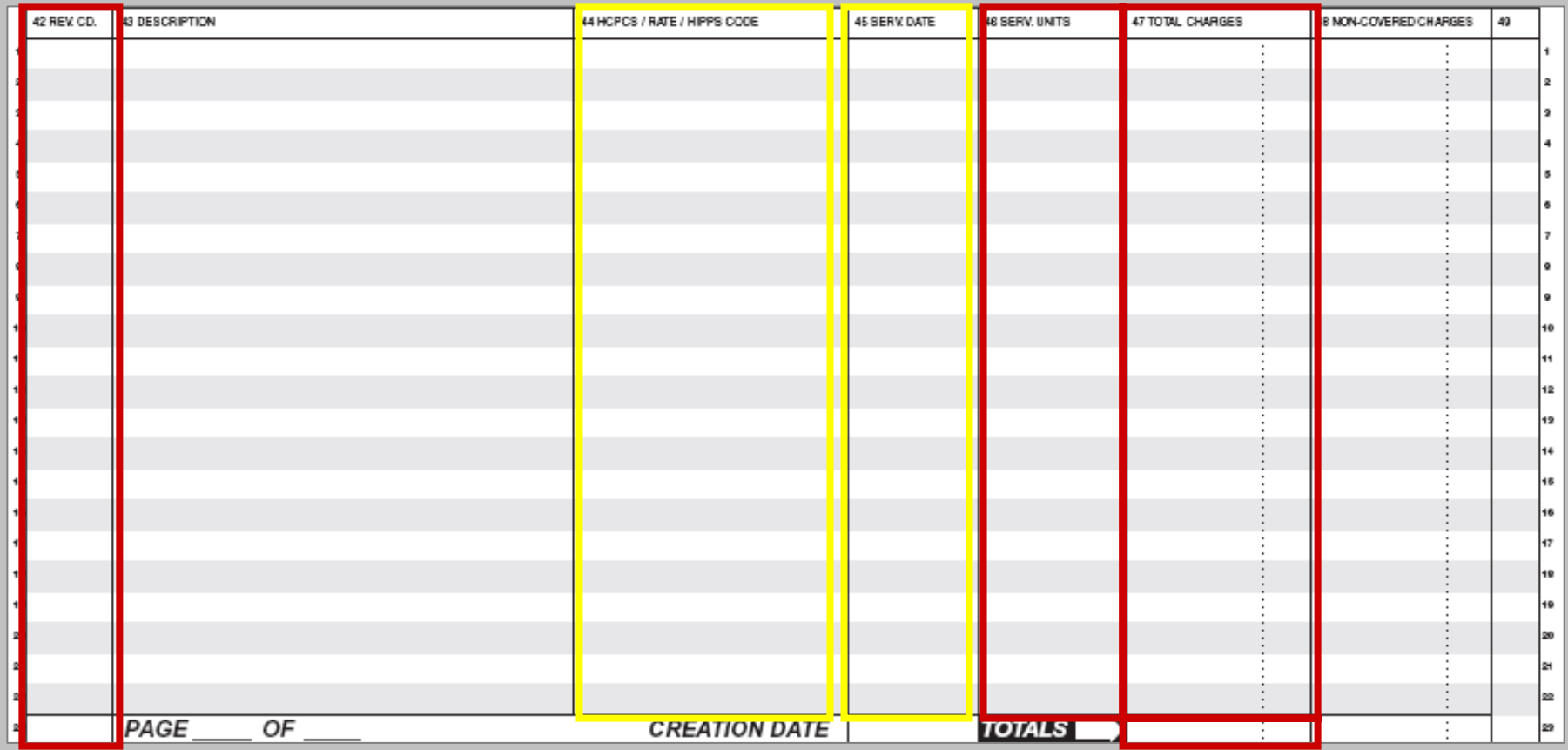
Box 40 - Optional



Value Codes

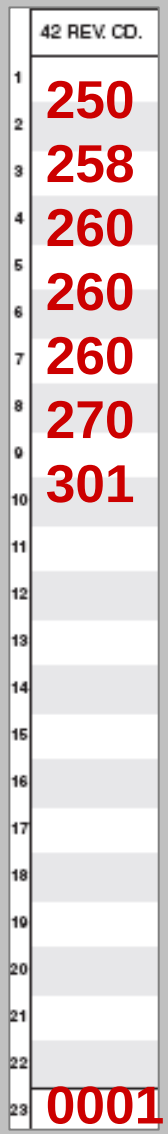
- Enter value code “A2” to identify Medicare Part B coinsurance.
- Enter Medicare Part B coinsurance dollar amount.

Middle section



Red = Required

Box 42 - Required



Revenue Center Codes

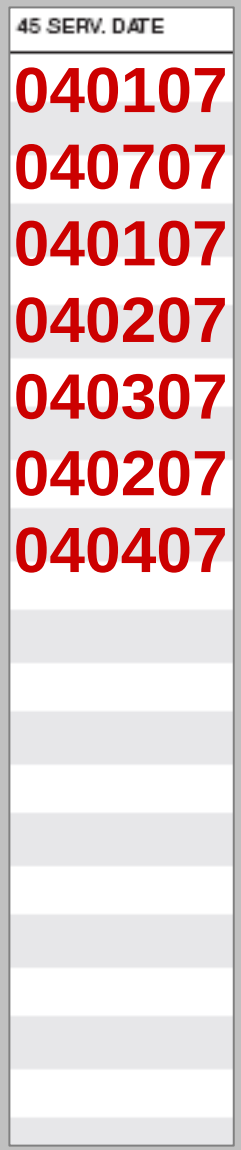
- Enter a three-digit revenue center code which most accurately describes the service provided.
- When using the same revenue center code, you must:
  - List a different CPT or HCPCS code for each service (see box 44) or use a different date of service (see box 45).
- Refer to your Hospital supplemental for a complete list of revenue center codes.

Box 44 - Optional

CPT or HCPCS

- CPT or HCPCS codes are required for most services.
- Refer to your Hospital supplemental for a complete list of revenue center codes.
- Revenue center codes that require a CPT or HCPCS are identified with an astrict (*).

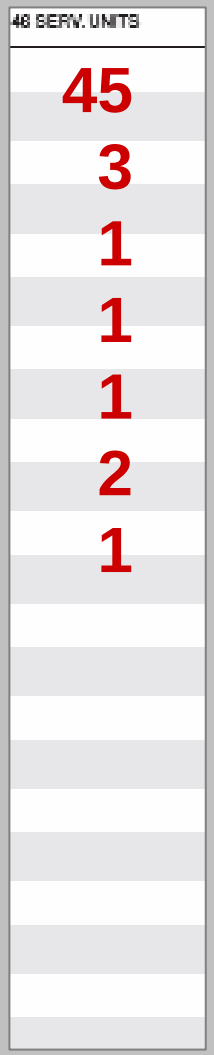
Box 45 - Optional



Service Date

- There are two acceptable methods to report your date of service.
  1. You may list each specific date of service for each revenue center code listed.
  2. You may bill for a series of services by leaving this box blank.
- If you use method two and bill for a service later with the same date range and same revenue center code, the claim may be denied as a duplicate.

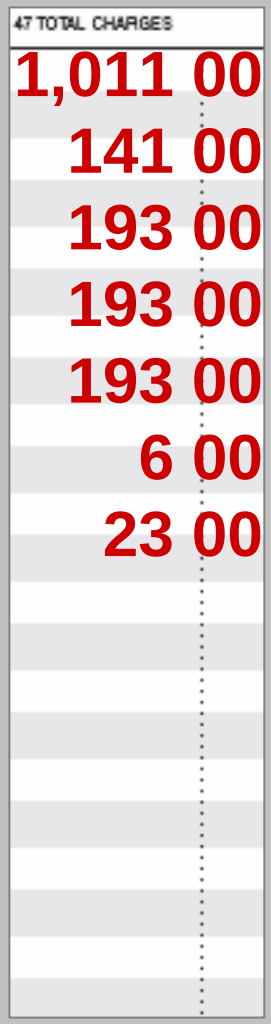
Box 46 - Required



Service Units

- 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



Total Charges

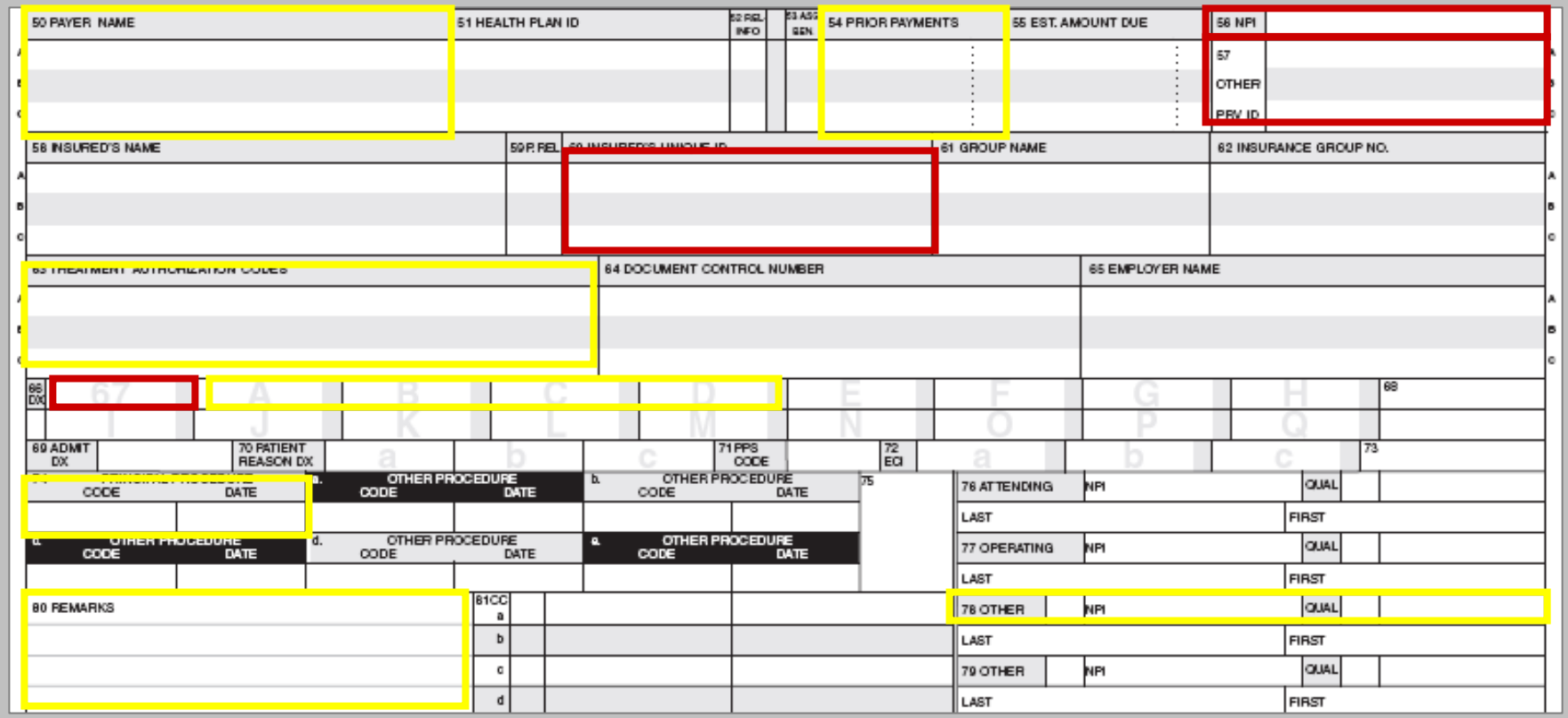
- Enter the total usual and customary charge for each related revenue center code listed.
- Do not list credits.
- Do not use dashes.

Total - Required

Total Charges

- Enter the total amount billed.
- Add the charges as indicated from column 47.
- Do not list credits.
- Do not use dashes.
- Each claim form is a separate document, and is to be totaled as such.

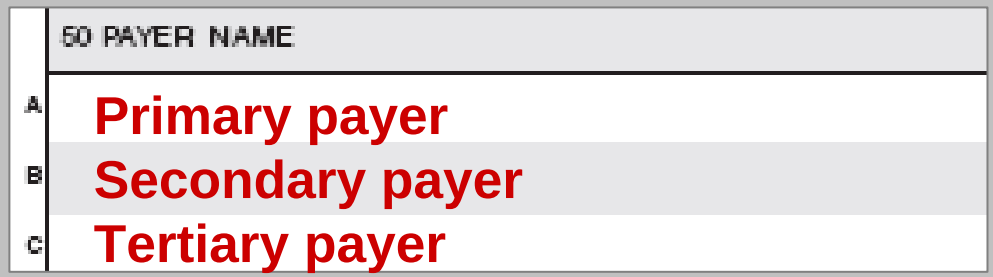
Bottom section



Red = Required

Yellow = Optional

Box 50 - Optional



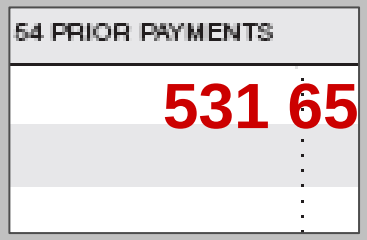
	50 PAYER NAME
A	**Primary payer**
B	**Secondary payer**
C	**Tertiary payer**

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

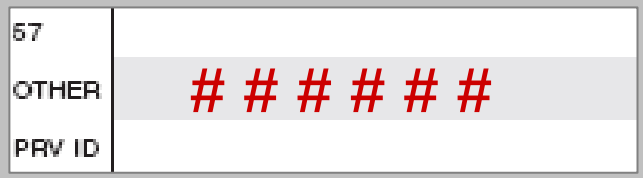
- Enter the total amount paid by other third party resource’s.
- Do not list write-off’s.
- Do not include how much DHS previously paid.
- Do not include copayments.
- Correspond the placement as outlined in box 50 instructions.

Box 56 - Required

National Provider Identifier (NPI)

- Enter the ten-digit NPI of the Hospital billing for services rendered.

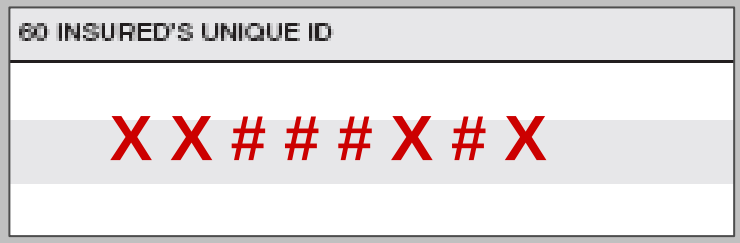
Box 57 - Required



Provider Number

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

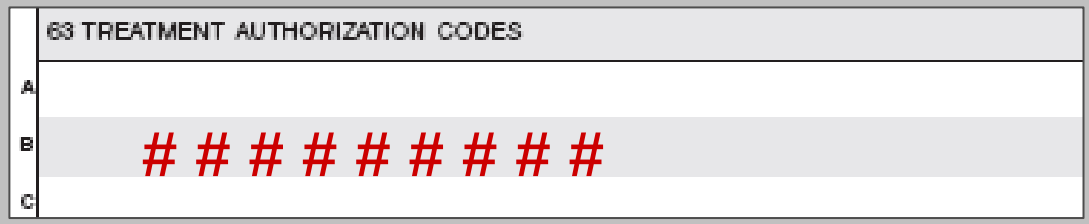
Box 60 - Required



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



Treatment Authorization

- If the service you provided requires prior authorization (PA), enter the nine-digit prior authorization number that was issued for the service.
- Only use one prior 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 causing this hospitalization.
- 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 74 - Optional

Principal Procedure

- This box is required if a procedure was performed.
- Enter the ICD-9-CM procedure code which best identifies the procedure completed.
- The principle procedure is the procedure performed for definitive treatment rather than for diagnostic or exploratory purposes.

Box 78 - Optional

78 OTHER		NPI ##########	QUAL		######

Referring Provider ID

- This box is only required when the recipient is referred by their Primary Care Manager (PCM) or Physician Care Organization (PCO).
- 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 six-nines are no longer required.

Box 80 - Optional

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 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
OT	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
MO	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurances)

COMPLETED

EXAMPLE

Hospital
PO Box ###
Anytown, OR 97###

3a PAT. CNTL. # X123400
4 TYPE OF BILL 131
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM 040107 THROUGH 040707
7 XOVR

8 PATIENT NAME: Patient, Your
9 PATIENT ADDRESS

10 BIRTHDATE
11 SEX
12 ADMISSION DATE 040107
13 HR 10
14 TYPE 2
15 SRC
16 DHR 15
17 STAT
18 19 20 21 CONDITION CODES 22 23 24 25 26 27 28
29 ACDT STATE
30

31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37

38

39 VALUE CODES CODE AMOUNT
a A1 250 00
40 VALUE CODES CODE AMOUNT
a A2 95 00
41 VALUE CODES CODE AMOUNT

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
250			040107	45	1,011 00		
258			040707	3	141 00		
260		Q0081	040107	1	193 00		
260		Q0081	040207	1	193 00		
260		Q0081	040307	1	193 00		
270		80053	040207	2	6 00		
301			040407	1	23 00		
				TOTALS	1,760 00		

0001 PAGE ____ OF ____ CREATION DATE

50 PAYER NAME: Medicaid
51 HEALTH PLAN ID
52 REL. INFO.
53 ASG. BEN.
54 PRIOR PAYMENTS 531 65
55 EST. AMOUNT DUE
56 NPI ##########
57 OTHER PRV ID ######

58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID XX###X#X
61 GROUP NAME
62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME

66 DX 7993
67 A B C D E F G H I J K L M N O P Q
68

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

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

80 REMARKS: UD
81CC a b c d

76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI ########## QUAL ###### LAST FIRST
79 OTHER NPI QUAL LAST FIRST

UB-04 CMS-1450 APPROVED OMB NO. NUBC National Uniform Billing Committee LIC9213257 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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!