Home Health 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).

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

			3a PAT. CNTL #		4 TYPE OF BILL
1		2	b. MED. REC. #		
			5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7

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

| 10 BIRTHDATE | 11 SEX | 12 DATE | ADMISSION 13 HR | 14 TYPE | 15 SRC | 16 DHR | 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
a						a
b						b

38		39 CODE VALUE CODES AMOUNT	40 CODE VALUE CODES AMOUNT	41 CODE VALUE CODES 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
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
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
B							OTHER
C							PRV ID

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
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	76 ATTENDING NPI QUAL
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		LAST FIRST
				77 OPERATING NPI QUAL
80 REMARKS	81CC a			LAST FIRST
	b			78 OTHER NPI QUAL
	c			LAST FIRST
	d			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.

UB-04 CMS-1450

Top section

Red = Required   Yellow = Optional

Box 1 - Optional

1 **Home Health**					
PO Box ###					
Anytown, OR 97###					

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

4 TYPE OF BILL

322

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 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.

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

12	DATE
040107	

Admission Date

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

Box 31 - Optional

31 OCCURRENCE	
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

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
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	PAGE _____ OF _____	CREATION DATE		TOTALS ▶			23

Red = Required

Box 42 - Required

42 REV. CD.
1
2 **270**
3 **424**
4 **559**
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23 **0001**

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

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

44 HCPCS / RATE / HIPPS CODE

#####

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

46 SERV. UNITS
6
7
3

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

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

TOTALS ➡ **230**:**30**

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

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

54 PRIOR PAYMENTS

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

56 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

66 DX	7993

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

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

80 REMARKS
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

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

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

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)

1		2		3a PAT. CNTL #	X123400		4 TYPE OF BILL
Home Health				b. MED. REC. #			**322**
PO Box ###				5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH	7	
Anytown, OR 97###					**040107 040707**		

8 PATIENT NAME	a		9 PATIENT ADDRESS	a			c	d		e
b **Patient, Your**			b							

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

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	40 VALUE CODES CODE AMOUNT	41 VALUE CODES CODE 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
270				**6**	**22 30**		
424		**#####**		**7**	**151 00**		
559				**3**	**57 00**		
0001	PAGE ____ OF ____	CREATION DATE		TOTALS ➡	**230 30**		

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

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

66 DX	**7993**							68

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

74 PRINCIPAL PROCEDURE CODE DATE	a. OTHER PROCEDURE CODE DATE	b. OTHER PROCEDURE CODE DATE	75	76 ATTENDING NPI	QUAL
c. OTHER PROCEDURE CODE DATE	d. OTHER PROCEDURE CODE DATE	e. OTHER PROCEDURE CODE DATE		77 OPERATING NPI	QUAL

80 REMARKS	81CC a	78 OTHER NPI **##########**	QUAL **######**
NC	b	LAST	FIRST
	c	79 OTHER NPI	QUAL
	d	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!