Maryland Department of Health
Medical Assistance

UB04 Hospital Billing Instructions & Revenue Code Matrix

Revised 06/07/2019

Medical Assistance Problem Resolution

Institutional Hotline: 410-767-5457

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COMPLETION OF UB-04 FOR HOSPITAL INPATIENT/OUTPATIENT SERVICES

The uniform bill for institutional providers is the UB-04 (CMS-1450). All institutional paper claims must be submitted using the UB-04 claim form.

The instructions are organized by the corresponding boxes or "Form Locators" on the paper UB-04 and detail only those data elements required for Medical Assistance (MA) paper claim billing. For electronic billing, please refer to the Maryland Medicaid 837-I Electronic Companion Guide, which can be found on our website: *http://mdh.maryland.gov/hipaa/transandcodesets.html*

The UB-04 is a uniform institutional bill suitable for use in billing multiple third party liability (TPL) payers. When submitting claims, complete all items required by each payer who is to receive a copy of the form. Instructions for completion are the same for inpatient and outpatient claims unless otherwise noted.

Medicaid began accepting the International Classification of Diseases, Tenth Revision (ICD-10) diagnosis and surgical procedure codes on October 1, 2015. The following changes apply to UB-04 Hospital billing for Inpatient Admissions and Outpatient Services:

- For Inpatient admissions ICD-10 CM diagnosis and surgical procedure codes will be required for discharges on or after October 1, 2015.
- For Outpatient services ICD-10 CM diagnosis and surgical procedure codes will be required for Dates of Service on or after October 1, 2015.

Please be aware that Maryland Medicaid has a maximum line item allowance on the UB04 of 50 lines per claim. The initial claim submitted should be billed with a Type of Bill Frequency Code of 1 or 2 and any subsequent claims with additional service lines should use a Type of Bill Frequency Code of 3 or 4.

The Maryland Medicaid statute of limitations for timely claim submission is as follows:

- Invoices for inpatient and outpatient services must be received within twelve (12) months of the date of discharge or date of service.
- Invoices for chronic, psychiatric, rehabilitation, mental and RTC facility hospital services must be received within 12 months of the month of service on the invoice.
- If a claim is received within the 12 month limit but rejected, resubmission will be accepted within 60 days of the date of rejection or within 12 months of the date of discharge (or month of service if chronic), whichever is the longer period. ***NOTE: Timely filing will not be overridden for situations where the claims are being resubmitted every 60 days meaning continuous billing/resubmission that are resulting from or have been determined as a provider failing to correct the error(s) identified by the Program.***
- If a claim is rejected because of late receipt, the patient may not be billed for that claim.
- If a claim is submitted and neither a payment nor a rejection is received within 90 days, the claim should be resubmitted.
- For any claim initially submitted to Medicare and for which services have been approved or denied, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.
- All third-party resources, such as insurance or Worker's Compensation, should be billed first and payment either received or denied before the Medical Assistance Program may be billed for any portion not covered. However, if necessary to meet the 12-month deadline for receipt of the claim(s), the Medical Assistance Program may be billed first and then reimbursed if the third-party payer makes payment later.

- Claims with dates of service over the 12 month statute will not be for overridden for timely filing unless one or more of the guidelines listed below is met:
  - The recipient was certified for retroactive Medicaid benefits;
  - The recipient won an appeal in which he/she was granted retroactive Medicaid benefits; and/or
  - The failure of the claim to pay was the Program's fault, each time the claim was adjudicated.

June 7, 2019 Updates: **Added** clarifying guidance regarding Frequency 5 – Late Charges Discountinued, FL 6 – Statement Covers Period (From-Through), FL 12 –Admission Date, and FL 74 –Principal Procedure Code.

NEW: **Billing for Audiology-Related Services:** Effective July 1, 2018, HealthChoice managed care organizations (MCOs) and the Maryland Medical Assistance Fee-for-Service program (FFS) will cover medically necessary **audiology services, hearing aids, cochlear implants, and auditory osseointegrated devices to participants regardless of age.** An audiologist or audiology center is required to submit a preauthorization, using their assigned Maryland Medicaid provider number, for any services being completed by the hospital for dates of service on or after July 1, 2018.

***PLEASE NOTE (for FFS claims):** While hospitals are unable to submit the preauthorization request for audiology services using the facility's assigned Maryland Medicaid provider number, the hospital **MUST** ensure that a preauthorization was submitted by the audiologist or audiology center and approved by the Department's UCA, prior to performing a surgery for a cochlear implant or an auditory osseointegrated device. For any surgeries requiring an overnight hospital stay, the hospital is still required to request preauthorization for the elective inpatient admission. If either of these preauthorizations are not obtained, the Department may recoup funds reimbursed to the hospitals for these procedures.

When billing for these services, hospitals should use **revenue codes in the 047x** series to indicate that the services are related to audiology. An **associated HCPCS code is required** to be noted on the UB04 in Form Locator 44 (USE: **L8614** to indicate the cochlear implant device and **L8690** to indicate the auditory osseointegrated device). ***For HealthChoice requirements please contact the recipients MCO.**

Invoices may be typed or printed. If printed, the entries must be legible. Do not use pencil or a red pen to complete the invoice. Otherwise, payment may be delayed or the claim rejected. On your Medicare EOB's **"MEDICARE"** on all Medicare/Medicare Advantage Plan EOMB's and claims; all are processed as Medicare. Completed invoices and documents are to be mailed to the following address:

Maryland Medical Assistance Program
Attention: Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203

NOTE: ***<u>For Problem claims (errors, out of statute etc.)</u>*** *please contact the Problem Resolution Unit to speak with a Representative at 410-767-5457 or 1-800-445-1199 /410-767-5503 (option 3) to discuss errors before sending. Inquiries should include all applicable documents and forms with a cover letter explaining the problem to:*

Maryland Medical Assistance Program
Attention: Problem Resolution Unit, Rm SS-5
PO Box 1935
Baltimore, MD 21203

<u>For LTC span related denial issues</u> *(claim denial EOB codes 211, 281 or 283) submit a spreadsheet reflecting patient name, ma #, exact from and through dates of service (mm/dd/yy) with appropriate certified 257 copies for*

correction by emailing mdh.ltcmapr@maryland.gov.

Adjustments should be completed when a specific bill has been issued for a specific provider, patient, payer, insured and "statement covers period" date(s); the bill has been **paid**; and a supplemental payment is needed. To submit an adjustment, a provider should complete a MDH-4518A, Adjustment Form and mail that form to the address below:

Maryland Medical Assistance Program
Attention: Adjustment Section
P.O. Box 13045
Baltimore, MD 21203

Specialty Mental Health claims must be submitted to APS at the following address:

- Beacon Health Options Maryland (**claims mailing address**)
  P.O. Box 1850
  Hicksville, NY 11802-1850
- Beacon Health Options Maryland (**non-claims related**)
  P.O. Box 166
  Linthicum, MD 21090

Call: 800-888-1965

ELIGIBILITY VERIFICATION SYSTEM (EVS)

It is the provider's responsibility to check EVS prior to rendering services to ensure recipient eligibility for a specific date of service.

Before providing services, you should request the recipient's Medical Care Program identification card. If the recipient does not have the card, you should request a Social Security number, which may be used to verify eligibility.

EVS is a telephone-inquiry system that enables health care providers to quickly and efficiently verify a Medicaid recipient's current eligibility status. It will tell you if the recipient is enrolled with a Managed Care Organization (MCO) or if they have third party insurance.

EVS also allows a provider to verify past dates of eligibility for services rendered up to one year ago. Also, if the Medical Assistance identification number is not available, you may search current eligibility and optionally past eligibility up to one year by using a recipient's Social Security Number and name code.

EVS is an invaluable tool to Medical Assistance providers for ensuring accurate and timely eligibility information for claim submissions. If you need additional information, please call the Provider Relations Unit at 410-767-5503 or 1-800-445-1159.

HOW TO USE EVS:

STEP 1: Call the EVS access telephone number by dialing the number for your area. EVS Telephone Number:

1-866-710-1447

EVS answers with the following prompt:

"Medicaid Eligibility Verification System. Attention: For past eligibility status checks, you must enter month, date and 4-position year. To end, press the pound (#) key. Please enter provider number."

STEP 2: Enter your 9-digit provider number and press pound (#).

EXAMPLE: 0 1 2 3 4 5 6 7 8 #

STEP 3: For Current Eligibility: Enter the 11-digit recipient number and the 2-digit name code (the first two letters of the last name converted into numeric touchtone numbers) and press pound (#).

EXAMPLE: For recipient Mary Stern, you would enter:

1 1 2 2 3 3 4 4 5 5 6	***78#***
Recipient Number	Last Name Code*

**Last Name Code: where 7 is for the S in Stern and 8 is for the T in Stern*

NOTE: *Since the characters Q and Z are not available on all touchtone phones, enter the digit 7 for the letter Q and digit 9 for the letter Z.*

For Past Eligibility: Enter a date of up to one-year prior using format MMDDYYYY.

EXAMPLE: For recipient Mary Stern, where the date of service was January 1, 2005, you would enter:

1 1 2 2 3 3 4 4 5 5 6	**78**	**0 1 0 1 2 0 0 5 #**
Recipient Number	Last Name Code	Service Date

NOTE: Use a zero for space if recipient has only one letter in the last name. Example: Malcolm X; Name Code X0

If the Recipient Number is Not Available: Press zero, pound, pound (0##) at the recipient number prompt and the system prompts you for a Social Security search. EVS will then prompt you with the following:

"Enter Social Security Number and Name Code"

Enter the recipient's 9-digit Social Security Number and 2-digit name code:

EXAMPLE:

1 1 1 2 2 3 3 3 3	**78#**
Social Security Number	Last Name Code

NOTE: Social Security Numbers are not on file for all recipients. Eligibility cannot be verified until the Medical Assistance number is obtained. If you have entered a valid Social Security Number and the recipient is currently eligible for Medical Assistance, EVS will provide you with a valid recipient number, which you should record with the current eligibility status.

STEP 4: Enter another recipient number or immediately press the pound button twice (# #) to end the call.

WebEVS

For providers enrolled in eMedicaid, WebEVS, a new web-based eligibility application is now available at **http://www.emdhealthchoice.org**. Providers must be enrolled in eMedicaid in order to access Web-EVS. To enroll, go to the URL above and select 'Services for Medical Care Providers' and follow the login instructions. If you need information, please visit the website or for provider application support call 410-767-5340.

Billing Provider Name and Address

2 Medicaid ICN **Leave Blank**

3a PAT. CNTL. # Patient Control Number

b. MED. REC. #

4 TYPE OF BILL XXX

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH Service Dates

7

8 PATIENT NAME a

9 PATIENT ADDRESS a

b Patient Name: Last Name, First

b c d e

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

Report when applicable

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 Report when applicable 76 999999 999999

b

38

Correct per UB04 Instructions = 5 days ¢
(Acceptable = 5 days) ¢

(Not correct = 500 da s) ¢

39 VALUE CODES CODE AMOUNT 40 VALUE CODES CODE AMOUNT 41 VALUE CODES CODE AMOUNT

a 80 66 801 23

b 00 5

c

d 80 5

42 REV. CD. 43 DESCRIPTION 44 HCPCS / RATE / HIPPS CODE 45 SERV. DATE 46 SERV. UNITS 47 TOTAL CHARGES 48 NON-COVERED CHARGES 49

4-Digit Codes 0XXX

National Drug Code (NDC) (Rev Code 025X, 0636 0637)

HCPCS (outpatient only) Refer to instructions for specific conditions and requirements for reporting

Cov'd & Non-Cov' Days/Srvcs

Total Cover d & Non-Covered Charges

Total Non-Covered Charges

PAGE ____ OF ____ CREATION DATE Create Date TOTALS

50 PAYER NAME 51 HEALTH PLAN ID 52 REL. INFO 53 ASG. BEN. 54 PRIOR PAYMENTS 55 EST. AMOUNT DUE 56 NPI NPI Number

When applicable

57 OTHER PRV ID Medicaid Legacy 9-digit provider

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

Patient's Medical ID
*Should always be last entry field

63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME

MDH 3808 Document Number

66 DX Required to match diagnosis codes on 3808 optional 68

Optional

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

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

Required inpatient claim ONLY

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

Optional

76 ATTENDING NPI NPI required QUAL MA 9-digit Prov.#

LAST FIRST

77 OPERATING NPI NPI required QUAL MA 9-digit Prov. #

LAST FIRST

78 OTHER NPI QUAL

LAST FIRST

79 OTHER NPI QUAL

LAST FIRST

80 REMARKS

Not Required - Optional

81CC a B3 Taxonomy Code

b Other Code – When Applicable

c

d

UB-04 CMS-1450 OMB APPROVAL PENDING

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NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

The instructions that follow are keyed to the form locator number and headings on the UB-04 form.

FL 01 **Billing Provider Name, Address, and Telephone Number**

Required. Enter the name and service location of the provider submitting the bill.

Line 1 Enter the provider name filed with the Medical Assistance Program.

Line 2 Enter the street address to which the invoice should be returned if it is rejected due to provider error.

Line 3 Enter the City, State & full nine-digit ZIP Code

Line 4 Telephone, Fax, County Code (Optional)

Note: Checks and remittance advices are sent to the provider's address as it appears in the Program's provider master file.

FL 02 **Pay-to Name and Address**

Leave Blank – Internal Use Only

FL 03a **Patient Control Number**

Required. Enter the patient's unique alphanumeric control number assigned to the patient by the hospital. A maximum of 20 positions will be returned on the remittance advice to the provider.

FL 03b **Medical/Health Record Number**

Optional. Enter the medical/health record number assigned to the patient by the hospital when the provider needs to identify for future inquiries the actual medical record of the patient. Up to 13 positions may be entered.

FL 04 **Type of Bill**

Required. Enter the 3-digit code (**do not report leading zero**) indicating the specific type of bill. Entering the leading zero will cause your claim to deny. The third digit indicates the bill sequence for this particular episode of care and is referred to as a "frequency" code. All three digits are required to process a claim.

Type of Bill: Inpatient and Outpatient Designation

The matrix that follows contains general guidelines on what constitutes an "inpatient" or "outpatient" claim according to the first three digits of Type of Bill (TOB), minus the leading zero. **Only those "Types of Bills" highlighted in grey are acceptable by Medical Assistance**.

"Types of Bills" marked NOT USED will be denied by Medicaid. The usage of many data elements is based on the inpatient/outpatient bill type designation. For example, HCPCS are reported on outpatient bills while ICD-9-CM procedure codes are reported on inpatient bills.

The "x" in the Type of Bill column of the matrix represents a placeholder for the frequency code. A list of the frequency codes follows the matrix.

Exceptions and augmentations to the general guidelines that result from specific data element requirements are documented at the end of the matrix.

Type of Bill **Do NOT report leading zero**	**Description**	**Inpatient/Outpatient General Designation**
0**000**-0**10x**	Reserved for Assignment by NUBC	-
0**11x**	Hospital Inpatient (including Medicare Part A)	IP
0**12x**	Hospital Inpatient (Medicare Part B ONLY)	OP
0**13x**	Hospital Outpatient	OP
0**14x**	Hospital – Laboratory Services to Non-Patients	OP (NOT USED)
0**15x**	Chronic Hospitals, Chronic Rehabilitation Hospitals, Specialty Chronic Hospitals	IP
0**16x**-0**17x**	Reserved for Assignment by NUBC	-
0**18x**	Hospital – Swing Beds	IP (NOT USED)
0**19x**-0**20x**	Reserved for Assignment by NUBC	-
0**21x**	Intermediate Care Facility – Mental Retardation	IP
0**21x**	Skilled Nursing – Inpatient (Including Medicare Part A)	IP *Nursing Home Claims*
0**22x**	Skilled Nursing – Inpatient (Medicare Part B)	OP *Nursing Home Therapy*
0**23x**	Skilled Nursing – Outpatient	OP (NOT USED)
0**24x**-0**27x**	Reserved for Assignment by NUBC	-
0**28x**	Skilled Nursing – Swing Beds	IP (NOT USED)
0**29x**-0**31x**	Reserved for Assignment by NUBC	-
0**32x**	Home Health – Inpatient (plan of treatment under Part B only)	-
0**33x**	Home Health – Outpatient (plan of treatment under Part A, including DME under Part A)	OP (NOT USED) *Home Health Agency*
0**34x**	Home Health – other (for medical and surgical services not under a plan of treatment)	OP (NOT USED)
0**35x**-0**40x**	Reserved for Assignment by NUBC	-
0**41x**	Religious Non-Medical Health Care Institutions – Inpatient Services	IP (NOT USED)
0**42x**	Reserved for Assignment by NUBC	-
0**43x**	Religious Non-Medical Health Care Institutions – Outpatient Services	OP (NOT USED)
0**44x**-0**64x**	Reserved for Assignment by NUBC	-
0**65x**	Intermediate Care Facility – Addictions	IP
0**66x**	Intermediate Care – Level II	IP (NOT USED)
0**67x**-0**70x**	Reserved for Assignment by NUBC	-

Type of Bill **Do NOT report leading zero**	**Description**	**Inpatient/Outpatient General Designation**
0**71x**	Clinic – Rural Health	OP (NOT USED)
0**72x**	Clinic – Hospital Based or Independent Renal Dialysis Center	OP *Free-Standing Dialysis*
0**73x**	Clinic – Freestanding	OP (NOT USED)
0**74x**	Clinic – Outpatient Rehabilitation Facility (ORF)	OP (NOT USED)
0**75x**	Clinic – Comprehensive Outpatient Rehabilitation Facility (CORF)	OP (NOT USED)
0**76x**	Clinic – Community Mental Health Center	OP (NOT USED)
0**77x**-0**78x**	Reserved for Assignment by NUBC	-
0**79x**	Clinic – Other	OP (NOT USED)
0**80x**	Reserved for Assignment by NUBC	-
0**81x**	Specialty Facility – Hospice Facility Services	IP
0**82x**	Specialty Facility – Hospice Nursing Home Room and Board Services	IP
0**83x**	Specialty Facility – Ambulatory Surgery Center	OP (NOT USED)
0**84x**	Specialty Facility – Free Standing Birthing Center	IP (NOT USED)
0**85x**	Specialty Facility – Critical Access Hospital	OP (NOT USED)
0**86x**	Specialty Facility – Residential Treatment Center	IP
0**90x**-9999	Reserved for Assignment by NUBC	NOT USED

Type of Bill Frequency Codes:		
1	Admit Through Discharge Claims	The provider uses this code for a bill encompassing an entire inpatient confinement for which it expects payment from the payer.
2	Interim Billing - First Claim	This code is to be used for the first (admit) of an expected series of bills for the same confinement or course of treatment for which the provider expects payment from the payer. FL 17 should equal “30”.
3	Interim Billing- Continuing Claim	This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted for which payment is expected from the payer. FL 17 should equal “30”.
4	Interim Billing - Last Claim	This code is to be used for the last (discharge) of a series of bills for the same confinement or course of treatment for which payment is expected from the payer.

Type of Bill Frequency Codes:		
5	Late Charge(s) Only Claim DISCONTINUED	Effective May 1, 2019 - Not Used.
6	Reserved for National Assignment by NUBC	NOT USED
7	Replacement of Prior Claim FUTURE USE – NOT USED	This code is to be used when a specific bill has been issued for a specific provider, patient, payer, insured and "statement covers period" and it needs to be restated in its entirety, except for the same identity information. In using this code, the payer is to operate on the principal that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill. This code is not intended to be used in lieu of a Late Charge(s) Only claim.
8	Void/Cancel of Prior Claim FUTURE USE – NOT USED	This code reflects the elimination in its entirety of a previously submitted bill for a specific provider, patient, insured and "statement covers period" dates. The provider may wish to follow a Void Bill with a bill containing the correct information when a Payer is unable to process a Replacement to a Prior Claim. The appropriate Frequency Code must be used when submitting the new bill.
F	Beneficiary Initiated Adjustment Claim – NOT USED	For intermediary use only, to identify adjustments initiated by the beneficiary.
G	CWF Initiated Adjustment Claim NOT USED	For intermediary use only, to identify adjustments initiated by CWF.
H	CMS Initiated Adjustments NOT USED	For intermediary use only, to identify adjustments initiated by CMS.
I	Intermediary Adjustment Claim (Other than QIO or Provider) NOT USED	For intermediary use only, to identify adjustments initiated by the intermediary.
J	Initiated Adjustment Claim – Other – NOT USED	For intermediary use only, to identify adjustments initiated by other entities.
K	OIG Initiated Adjustment Claim NOT USED	For intermediary use only, to identify adjustments initiated by the OIG.
M	MSP Initiated Adjustment Claim NOT USED	For intermediary use only, to identify adjustments initiated by MSP. Note: MSP takes precedence over other adjustment sources.
N	QIO Adjustment Claims NOT USED	For intermediary use only, to identify an adjustment initiated because of QIO review.

Type of Bill Frequency Codes:		
O	Non-Payment/Zero Claim NOT USED	This code is to be used when a bill is submitted to a payer, but the provider does not anticipate a payment as a result of submitting the bill; but needs to inform the payer of the non-reimbursable periods of confinement or termination of care.
X	Void/Cancel a Prior Abbreviated Encounter Submission NOT USED	This code is used by a Medicare Advantage contractor or other plan required to submit encounter data that indicates that this encounter data submission is an exact duplicate of an incorrect previous encounter data submission using the abbreviated UB04 format. A code "Y" (replacement of prior abbreviated encounter submission) is also submitted by the plan showing corrected information.
Y	Replacement of Prior Abbreviated Encounter Submission NOT USED	This code is used by a Medicare Advantage contractor or other plan required to submit encounter data when it wants to correct a previous encounter submission using the abbreviated UB04 format. This is the code applied to the corrected or new encounter.
Z	New Abbreviated Encounter Submission NOT USED	This code is used by a Medicare Advantage contractor or other plan required to submit encounter data to indicate it is submitting new encounter data using the abbreviated UB04 format. It is applicable for both inpatient and outpatient services.

Note: Frequency codes "7" and "8" and "F-Z" will be available in the future. Do not use them until notified of their availability. Use of these codes currently will result in rejection of your invoice.

FL 05 **Federal Tax Number**

Not required. The number assigned to the provider by the federal government for tax reporting purposes. The format is: NN-NNNNNNN; 10 positions (include hyphen). For electronic claims, do not report the hyphen.

FL 06 **Statement Covers Period (From - Through)**

Required. Enter the beginning and ending service dates for the period covered on the claim (MMDDYY) as the "From" and "Through" dates. The "From" date represents the earliest date of service on the bill and the "Through" date equals the date through which Medicaid is paying for accommodations. Remember that Medical Assistance does not pay for accommodations for the date of death/discharge. The date of death/discharge should never be shown as the "Through" date in this field.

A: For all services received on a single day, both the "From" and "Through" dates will be the same. For outpatient services, only one date of service may be billed on a single UB-04. (Continued treatment must be billed on a day-to-day basis).

B: The dates on each service line must be between the "From" and "Through" dates on the claim.

C: "Split" billing. All charges for an admission must be included on a single invoice. An acute care hospital may not "split" a Medical Assistance bill except for the conditions:

1. A gap has occurred in Medical Assistance eligibility.
2. The MDH 3808, Admission and Length of Stay Certification, shows multiple approval and denial date ranges during the same inpatient stay.
3. Family planning and sterilization charges and services must be separated from non-sterilization charges and services. (Vaginal deliveries only).
4. Abortion charges and services must be separated from non-abortion charges and services.
5. Medicare coinsurance and deductible amounts must be billed separately from non-Medicare covered regular charges.
6. Administrative Days must be billed separately from acute hospital days and the DHMH 1288, Report of Administrative Days form must be attached.

D: Medicare Part A and Part B claims should use the "From" and "Through" dates as indicated on the Medicare EOMB.

Notes:

* The admission date (FL 12) must be between the "From" and "Through" dates but can be

no more than 3 calendar days after the "From" date, except when the type of Bill Frequency Code is 3 or 4.

* The Principle Procedure dates (FL 74) must be between the "From" and "Through" dates, except when the Type of Bill Frequency Code is 3 or 4.

FL 07 **Reserved for Assignment by NUBC**

NOT USED

FL 08a **Patient Name – Identifier**

Not required. Patient's ID (if different than the subscriber/insured's ID).

FL 08b **Patient Name**

Required. Enter the patient's name as it appears on the Medical Assistance card: last name, first name, and middle initial. (Please print this information clearly.)

If you are billing for a newborn, you must use the newborn's full name.

FL 09, 1a-2e **Patient Address**

Optional. Enter the patient's complete mailing address, as follows:

Line 1a -- Enter the patient address – Street (or P.O. Box) Line
2b -- Enter the patient address – City
Line 2c -- Enter the patient address – State
Line 2d -- Enter the patient address –Zip
Line 2e -- Enter the patient address –Country Code (Report if other than USA)

FL 10 **Patient Birth Date**

Required. Enter the month, day, and year of birth (MMDDYYYY). Example: 11223333

FL 11 **Patient Sex**

Not required. Enter the patient's sex as recorded at admission, outpatient service, or start of care.

M – Male F – Female U – Unknown

FL 12 **Admission Date**

Required. Enter the date the patient was admitted to the provider for inpatient care, outpatient services or the start of care. Enter the date as (MMDDYY). The admission date must be between the "From" and "Through" dates (FL 6) but can be no more than 3 calendar days after the "From" date, with the exception of Type of Bill Frequency Codes of 3 or 4.

Note: Chronic, psych, mental, rehab and RTC facilities should enter the date of admission for the first month of billing only.

FL 13 **Admission Hour**

Required on all inpatient claims except for bill type 021x. Optional for outpatient billing. Enter the code for the hour during which the patient was admitted for inpatient or outpatient care from the following table:

CODE STRUCTURE:

Code	Time	Code	Time
00	12:00-12:59 Midnight	12	12:00-12:59 Noon
01	01:00-01:59	13	01:00-01:59
02	02:00-02:59	14	02:00-02:59
03	03:00-03:59	15	03:00-03:59
04	04:00-04:59	16	04:00-04:59
05	05:00-05:59	17	05:00-05:59
06	06:00-06:59	18	06:00-06:59
07	07:00-07:59	19	07:00-07:59
08	08:00-08:59	20	08:00-08:59
09	09:00-09:59	21	09:00-09:59
10	10:00-10:59	22	10:00-10:59
11	11:00-11:59	23	11:00-11:59

FL 14 **Priority (Type) of Visit**

Required for inpatient billing only. Enter the code indicating priority of this admission.

Code Structure – Priority (Type of Visit)		
1	Emergency	The patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room
2	Urgent	The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.
3	Elective	The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4	Newborn	Use of this code necessitates the use of a special Source of Admission code - see FL 15.
5	Trauma Center	Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation. (Use Revenue Code 068x to capture trauma activation charges.)
9	Information not Available NOT USED	Information not available.

FL 15 **Source of Referral for Admission or Visit**

Required for all inpatient admissions. Enter the code indicating the source of the referral for this admission or visit. Optional for outpatient claims.

NOTE: Newborn coding structure must be used when the Priority (Type) of Visit Code in FL 14 is code 4.

Code Structure: Source of Referral for Admission or Visit		
1	Physician Referral	Inpatient: The patient was admitted to this facility upon the recommendation of his or her personal physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).
2	Clinic Referral	Inpatient: The patient was admitted to this facility upon recommendation of this facility's clinic physician. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.
3	HMO Referral	Inpatient: The patient was admitted to this facility upon the recommendation of a health maintenance organization physician. Outpatient: The patient was referred to this facility for outpatient, or referenced diagnostic services, by a health maintenance organization's physician.
4	Transfer from a Hospital (Different Facility*) *For transfers from Hospital Inpatient in the Same Facility, see Code D	Inpatient: The patient was admitted to this facility as a hospital transfer from a different acute care facility where he or she was an inpatient. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) a different acute care facility.
5	Transfer from a Skilled Nursing Facility	Inpatient: The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was a resident. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) the skilled nursing facility where he or she is a resident.

6	Transfer from Another Health Care Facility	Inpatient: The patient was admitted to this facility as a transfer from a health care facility other than an acute care facility or a skilled nursing facility. This includes transfers from nursing homes, long term care facilities and skilled nursing facility patients that are at a non-skilled level of care. Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by (a physician of) another health care facility where he or she is an inpatient.

Code Structure: Source of Referral for Admission or Visit		
7	Emergency Room	Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician. Outpatient: The patient received services in this facility's emergency department.
8	Court/Law Enforcement	Inpatient: The patient was admitted to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative. Outpatient: The patient was referred to this facility upon the direction of a court of law, or upon the request of a law enforcement agency representative for outpatient or referenced diagnostic services.
9	Information not Available NOT USED	Inpatient: The means by which the patient was admitted to this hospital is not known. Outpatient: For Medicare outpatient bills this is not a valid code.

Code Structure for Newborn		
1	Normal Delivery	A baby delivered without complications
2	Premature Delivery	A baby delivered with time and/or weight factors qualifying it for premature status.
3	Sick Baby	A baby delivered with medical complications, other than those relating to premature status.
4	Extramural Birth	A newborn born in a non-sterile environment.

FL 16 **Discharge Hour**

Not required. Report on inpatient claims with a frequency code of 1 or 4, except for Type of Bill 021x.

FL 17 **Patient Discharge Status**

Required for all inpatient claims. Enter a code from the code structure below indicating the patient's disposition or discharge status at the time of billing for that period of inpatient care.

Under Medicare's post acute care transfer policy (from 42 CFR 412.4), a discharge of a hospital inpatient is considered to be a transfer when the patient's discharge is assigned to one of the

qualifying diagnosis-related groups (DRGs) and the discharge is made under any of the following circumstances:

- To a hospital or distinct part of a hospital unit excluded from the inpatient prospective payment system (Inpatient Rehabilitation Facilities, Long Term Care Hospitals, psychiatric hospitals, cancer hospitals, and children's hospitals).
- To a skilled nursing facility (not swing beds).
- To home under a written plan of care for the provision of home health services from a home health agency and those services begin within 3 days after the date of discharge.

Based on regulation, providers code these transfers with 62, 63, 65, 05, 03 and 06.

Code Structure: Patient Discharge Status	
01	Discharged to self or home care (routine discharge) Usage Notes: Includes discharge to home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs; assisted living facilities that are not state-designated.
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of skilled care. Usage Notes: Medicare – Indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with approved swing bed arrangement, use Code 61 – Swing Bed. For reporting other discharges/transfers to nursing facilities, see 04 and 64.
04	Discharged/transferred to an intermediate care facility (ICF) Usage Notes: Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.
05	**Definition effective 4/1/08:** Discharged/transferred to a Designated Cancer Center or Children's Hospital Usage Notes: Transfers to non-designated cancer hospitals should use Code 02. A list of (National Cancer Institute) Designated Cancer Centers can be found at: http://www3.cancer.gov/cancercenters/centerslist.html
06	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care. Usage Notes: Report this code when the patient is discharged/transferred to home with a written plan of care for home care services. Not used for home health services provided by a DME supplier or from a Home IV provider for home IV services.
07	Left against medical advice or discontinued care

09	Admitted as an Inpatient to this Hospital Usage Notes: For use only on Medicare outpatient claims. Applies only to those Medicare outpatient services that begin greater than three days prior to an admission.
20	Expired
30	Still a patient Usage Notes: Used when patient is still within the same facility; typically used when billing for leave of absence days or interim bills.

Code Structure: Patient Discharge Status	
43	Discharge/Transferred to a Federal Healthcare Facility Usage Notes: Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration's nursing facility.
50	Hospice – Home
51	Hospice – Medical Facility (Certified) Providing Hospice Level of Care
61	Discharged/Transferred to a Hospital-based Medicare Approved Swing Bed Usage Notes: Medicare – used for reporting patients discharged/transferred to a SNF level of care within the hospital's approved swing bed arrangement.
62	Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital
63	Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH)
64	Discharged/Transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare
65	Discharged/Transferred to a Psychiatric Hospital or Psychiatric distinct Part Unit of a Hospital
66	Discharged/Transferred to a Critical Access Hospital (CAH)
70	Effective **4/1/08**: **NOT USED** Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List (see Code 05)

FL 18-28 **Condition Codes**

Required when there is a condition code that applies to this claim. Enter the corresponding code used to describe any of the following conditions or events that apply to this billing period that may affect processing.

If all of the Condition Code fields are filled, use FL 81 Code-Code field with the appropriate qualifier code (A1) to indicate that a Condition Code is being reported (see FL 81 for more information).

Note: Condition Codes should be entered in alphanumeric sequence. However, report any Condition Codes required to process your Maryland Medicaid claim first; then continue to report other Condition Codes as needed in alphanumeric sequence. Maryland Medicaid will only capture 7 Condition Codes, including those reported in FL 81.

Code Structure - Condition Codes:		
01	Military Service Related	Medical condition incurred during military service.
02	Condition is Employment Related	Patient alleges that medical condition is due to environment/events resulting from employment.
03	Patient Covered by Insurance not Reflected Here	Indicates that patient/patient representative has stated that coverage may exist beyond that reflected on this bill.
04	Information Only Bill	Indicates submission of bill is for informational purposes only. Examples would include a bill submitted as a utilization report or a bill for a beneficiary who enrolled in a risk-based managed care plan and the hospital expects to receive payment from the plan.
05	Lien Has Been Filed	Provider has filed legal claim for recovery of funds potentially due a patient as a result of legal action initiated by or on behalf of the patient.
06	ESRD Patient in First 18 Months of Entitlement Covered by Employer Group Health Insurance	Code indicates Medicare as the secondary insurer because the patient also is covered through an employer group health insurance during his first 18 months of End Stage Renal Disease (ESRD) entitlement.
07	Treatment of Non-Terminal Condition for Hospice Patient	Code indicates the patient is a hospice enrollee, but the provider is not treating his terminal condition and is therefore requesting regular Medicare reimbursement.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Enter this code if the beneficiary would not provide information concerning other insurance coverage.
09	Neither Patient Nor Spouse is Employed	Indicates that in response to development questions, the patient and spouse have denied any employment.
10	Patient and/or Spouse is Employed but No EGHP Exists	Code indicates that in response to development questions, the patient and/or spouse have indicated that one is or both are employed but have no group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary but No LGHP	Code indicates that in response to development questions, the disabled beneficiary and/or family members have indicated that one is or more are employed but have no group health insurance from an LGHP or other employer sponsored or provided health insurance that covers the patient.
17	Patient is Homeless	The patient is homeless

Code Structure - Condition Codes:		
18	Maiden Name Retained	A dependent spouse entitled to benefits who does not use her husband's last name.
19	Child Retains Mother's Name	A patient who is a dependent child entitled to benefits and does not have its father's last name.
21	Billing for Denial Notice	Provider realizes services are non-covered level or excluded, but requests notice from Medicare or other payer.
22	Patient on Multiple Drug Regimen	A patient who is receiving multiple intravenous drugs while on home IV therapy
23	Home Care Giver Available	The patient has a caregiver available to assist him or her during self-administration of an intravenous drug.
24	Home IV Patient Also Receiving HHA Services	The patient is under the Care of Home Health Agency while receiving home IV drug therapy services.
25	Patient is Non-U.S. Resident	The patient is not a resident of the United States.
26	VA Eligible Patient Chooses to Receive Services in a Medicare Certified Facility	Indicates that the patient is a VA eligible patient and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	To be reported by Sole Community Hospitals only. Report this code to indicate the patient was referred for a diagnostic laboratory test. Do not report this code when a specimen only is referred.
28	Patient and/or Spouse's EGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or spouse have indicated that one is or both are employed and that there is a group health insurance from an EGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full and part-time employees; or (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	Code indicates that in response to development questions, the patient and/or family member(s) have indicated that one is or more are employed. There also is group health insurance coverage from a LGHP or other employer sponsored or provided health insurance that covers the patient. Generally, (1) the LGHP is a single employer plan and the employer has fewer than 100 full and part-time employees; or (2), the LGHP is a multiple employer plan and all employers

Code Structure - Condition Codes:		
		participating in the plan have fewer than 100 full and part-time employees.
30	Qualifying Clinical Trials	Non-research services provided to patients enrolled in a Qualified Clinical Trial.
31	Patient is Student (Full Time-Day)	Patient declares that he or she is enrolled as a full time day student.
32	Patient is Student (Cooperative/Work Study Program)	Self-explanatory.
33	Patient is Student (Full Time-Night)	Patient declares that he or she is enrolled as a full time night student.
34	Patient is Student (Part Time)	Patient declares that he or she is enrolled as a part time student.
36	General Care Patient in a Special Unit	Patient temporarily placed in a special care unit bed because no general care beds available.
37	Ward Accommodation at Patient Request	Patient assigned to ward accommodations at patient's request.
38	Semi-Private Room not Available	Indicates that either private or ward accommodations were assigned because semi-private accommodations were not available.
39	Private Room Medically Necessary	Patient needs a private room for medical requirements. Give justification on the 3808.
40	Same Day Transfer	Patient transferred to another facility before midnight on the day of admission.
41	Partial Hospitalization	Indicates claim is for partial hospitalization services.
42	Continuing Care Not Related to Inpatient Admission	Continuing care not related to the condition or diagnosis for which the individual received inpatient hospital services.
43	Continuing Care Not Provided Within Prescribed Post-Discharge Window	Continuing care related to the inpatient admission but the prescribed care was not provided with the post-discharge window.
44	Inpatient Admission Changed to Outpatient	For use on outpatient claims only, when the physician ordered inpatient services, but upon internal utilization review performed before the claim was originally submitted, the hospital determined that the services did not meet its inpatient criteria. (Note: For Medicare, the change in patient status from inpatient to outpatient is made prior to a discharge or release, while the beneficiary is still a patient of the hospital.)
45	Ambiguous Gender Category	Claim indicates patient has ambiguous gender characteristics (e.g. transgender or hermaphrodite).

Code Structure - Condition Codes:		
46	Non-Availability Statement on File	A non-availability statement must be issued for each TRICARE claim for non-emergency inpatient care when the TRICARE beneficiary resides within the catchment's area (usually a 40-mile radius) of a Uniformed Services Hospital).
48	Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)	Code to identify claims submitted by a "TRICARE-authorized" psychiatric Residential Treatment Center (RTC) for Children and Adolescents.
49	Product Replacement within Product Lifecycle	Replacement of a product earlier than the anticipated lifecycle due to an indication that the product is not functioning properly.
50	Product Replacement for Known Recall of a Product	Manufacturer or FDA has identified the product for recall and therefore replacement.
55	SNF Bed Not Available	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	Code indicates the patient's SNF admission was delayed more than 30 days after hospital discharge because his condition made it inappropriate to begin active care within that period.
57	SNF Readmission	Code indicates the patient was previously receiving Medicare covered SNF care within 30 days of this readmission.
58	Terminated Medicare Advantage Enrollee	Code indicates that patient is a terminated enrollee in a Medicare Advantage plan whose three-day inpatient hospital stay was waived.
59	Non-primary ESRD Facility	Code indicates that ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD dialysis facility.
60	Day Outlier	A hospital being paid under a prospective payment system is reporting this stay as a day outlier.
61	Cost Outlier	A hospital being paid under a prospective payment system is requesting additional payment for this stay as a cost outlier.
66	Provider Does Not Wish Cost Outlier Payment	A hospital paid under a prospective payment system is NOT requesting additional payment for this stay as a cost outlier.
67	Beneficiary Elects Not to Use Life Time Reserve (LTR) Days	Indicates beneficiary elects not to use LTR days.
68	Beneficiary Elects to use Life Time Reserve (LTR) Days	Indicates beneficiary has elected to use LTR days when charges are less than LTR coinsurance amounts.

Code Structure - Condition Codes:		
69	IME/DGME/N&AH Payment Only	Code indicates a request for a supplemental payment for IME/DGME/N&AH (Indirect Medical Education/Graduate Medical Education/ Nursing and Allied Health).
71	Full Care in Unit	Code indicates the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit	Code indicates the billing is for a patient who managed his own dialysis services without staff assistance in a hospital or renal dialysis facility.
73	Self-Care Training	Code indicates the billing is for special dialysis services where a patient and their helper (if necessary) were learning to perform dialysis.
74	Home	Code indicates the billing is for a patient who received dialysis services at home, but where code 75 below does not apply.
75	Home - 100% Reimbursement	Code indicates the billing is for a patient who received dialysis services at home, using a dialysis machine that was purchased by Medicare under 100 percent program. ***(Code is no longer used for Medicare.)***
76	Back-up in Facility Dialysis	Code indicates the billing is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/ Required due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full.	Code indicates you have accepted, or are obligated/required due to a contractual arrangement or law to accept, payment as payment in full. Therefore, no payment is due.
78	New Coverage Not Implemented by Managed Care Plan	Billing is for a newly covered service for which the managed care plan/HMO does not pay. (Note: For outpatient bills Condition Code 04 should be omitted).
79	CORF Services Provided Offsite	Enter this code to indicate that physical therapy, occupational therapy, or speech pathology services were provided offsite.
A0	TRICARE External Partnership Program	This code identifies TRICARE claims submitted under the External Partnership Program.
A1	EPSDT/CHAP	Early and Periodic Screening, Diagnosis and Treatment.
A2	Physically Handicapped Children's Program	Services provided under this program receive special funding through Title VII of the Social Security Act of the TRICARE Program for the Handicapped.
A3	Special Federal Funding	This code has been designed for uniform use as defined by State law.

Code Structure - Condition Codes:		
A4	Family Planning	This code has been designed for uniform use as defined by State law.
A5	Disability	This code has been designed for uniform use as defined by State law.
A6	Vaccines/Medicare 100% Payment	This code identifies that pneumococcal pneumonia and influenza vaccine services are reimbursed under special Medicare program provisions and Medicare deductible and coinsurance requirements do not apply.
A7	NOT USED	Reserved for Assignment by NUBC
A8	NOT USED	Reserved for Assignment by NUBC
A9	Second Opinion Surgery	Services requested to support second opinion on surgery. Part B deductible and coinsurance do not apply.
AA[(a)]	Abortion Performed due to Rape	Code indicates abortion performed due to a rape.
AB[(a)]	Abortion Performed due to Incest	Code indicates abortion performed due to an incident of incest.
AC[(a)]	Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality	Code indicates abortion performed due to a genetic defect, a deformity, or abnormality to the fetus.
AD[(a)]	Abortion Performed due to a Life Endangering Physical Condition	Code indicates abortion performed due to a life endangering physical condition caused by, arising from, or exacerbated by, the pregnancy itself.
AE[(a)]	Abortion Performed due to Physical Health of Mother that is not Life Endangering	Code indicates abortion performed due to physical health of mother that is not life endangering.
AF[(a)]	Abortion Performed due to Emotional/Psychological Health of the Mother	Code indicates abortion performed due to emotional/psychological health of the mother.
AG[(b)]	Abortion Performed due to Social or Economic Reasons	Code indicates abortion performed due to social or economic reasons.
AH[(b)]	Elective Abortion	Elective abortion.
AI	Sterilization	Sterilization.
AJ	Payer Responsible for Co-Payment	Payer responsible for co-payment.
AK	Air Ambulance Required	For ambulance claims. Air ambulance required; time needed to transport poses a threat.
AL	Specialized Treatment/Bed Unavailable – Alternate Facility Transport	For ambulance claims. Specialized treatment/bed unavailable. Transport to alternate facility.
AM	Non-Emergency Medically Necessary Stretcher Transport Required	For ambulance claims. Non-emergency medically necessary stretcher transport required.
AN	Preadmission Screening Not Required	Person meets the criteria for an exemption from preadmission screening.

Code Structure - Condition Codes:		
B0	Medicare Coordinated Care Demonstration Claim	Patient is a participant in the Medicare Coordinated Care Demonstration.
B1	Beneficiary is Ineligible for Demonstration Program	Beneficiary is ineligible for demonstration program.
B2	Critical Access Hospital Ambulance Attestation	Attestation by Critical Access Hospital that it meets the criteria for exemption from the ambulance fee schedule.
B3	Pregnancy Indicator	Indicates patient is pregnant. Required when mandated by law; determination of pregnancy completed in compliance with applicable law.
B4	Admission Unrelated to Discharge on Same Day	Report code when a patient is discharged/ transferred from an acute care PPS hospital on the same day for symptoms unrelated to and/or not for evaluation and management of, the prior stay's medical condition.
C1	Approved as Billed	The services provided for this billing period have been reviewed by the QIO or intermediary, as appropriate, and are fully approved including any day or cost outlier.
C2	Automatic Approval As Billed Based on Focused Review	This should include only categories of cases that the QIO has determined it need not review under a focused review program. (No longer used for Medicare).
C3	Partial Approval	Services provided for this billing period have been reviewed by the QIO (or intermediary as appropriate) and some portion (days or services) has been denied.
C4	Admission/Services Denied	This should only be used to indicate that all of services were denied by the QIO.
C5	Post Payment Review Applicable	This should be used to indicate that the QIO review will take place after payment.
C6	Admission Pre-Authorization	The QIO authorized this admission/service but has not reviewed the services provided.
C7	Extended Authorization	The QIO has authorized these services for an extended length of time but has not reviewed the services provided.
D0	Changes to Service Dates **(FUTURE USE)**	Changes to service dates.
D1	Changes to Charges **(FUTURE USE)**	Changes to charges.
D2	Changes in Revenue Codes/HCPCS/ HIPPS Rate Codes **(FUTURE USE)**	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in Revenue Codes (FL42)/ HCPCS/HIPPS Rate Codes (FL44).

Code Structure - Condition Codes:		
D3	Second or Subsequent Interim PPS Bill **(FUTURE USE)**	Second or subsequent interim PPS bill.
D4	Change in Clinical Codes (ICD) for Diagnosis and/or Procedure Codes **(FUTURE USE)**	Report this claim change reason code on a replacement claim (Bill Type Frequency Code 7) to reflect a change in diagnosis (FL 67) and procedure codes (FL 74).
D5	Cancel to Correct Insured's ID or Provider ID **(FUTURE USE)**	Cancel only to correct insured's ID or provider identification number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment **(FUTURE USE)**	Cancel only to repay a duplicate payment or OIG overpayment. (Includes cancellation of an outpatient bill containing services required to be included on the inpatient bill).
D7	Change to Make Medicare the Secondary Payer **(FUTURE USE)**	Change to make Medicare the secondary payer.
D8	Change to Make Medicare the Primary Payer **(FUTURE USE)**	Change to make Medicare the primary payer.
D9	Any Other Change **(FUTURE USE)**	Any other change.
DR	Disaster Related	Used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster.
E0	Change in Patient Status **(FUTURE USE)**	Change in patient status.
G0	Distinct Medical Visit	Report this code when multiple medical visits occurred on the same day in the same revenue center but the visits were distinct and constituted independent visits. An example of such a situation would be a beneficiary going to the emergency room twice on the same day, in the morning for a broken arm and later for chest pain.
H0	Delayed Filing; Statement of Intent Submitted	Code indicates submission of "Statement of Intent" within the qualifying period to specifically identify the existence of another third party liability situation.
P1	Do Not Resuscitate Order (DNR)	FOR PUBLIC HEALTH REPORTING ONLY. Code indicates that a DNR order was written at the time of or within the first 24 hours of the patient's admission to the hospital and is clearly documented in the patient's medical record.
W0	United Mine Workers of America (UMWA) Demonstration Indicator	Used for United Mine Workers of America (UMWA) demonstration indicator ONLY.

NOTE:
UB04 claims reporting abortion, sterilization or hysterectomy diagnosis or procedure codes may be billed without attachment. Please follow the instructions below for each service when submitting electronically or via paper.

Abortion:
UB04 claims reporting abortion diagnosis or procedure codes must also report an abortion condition code (AA-AH) from the above table.

(a) UB04 claims reporting abortion condition codes AA-AF are covered by the Medicaid Program and do not require attachment of the DHMH 521 form. These claims may be billed electronically to Maryland Medicaid for payment. The DHMH 521-Certification for Abortion form must be kept in the patient's Medical Record.

(b) UB04 claims reporting abortion condition code AG or AH are not covered by the Medicaid Program.

Sterilization:
UB04 claims reporting sterilization diagnosis or procedure codes do not require condition code reporting and do not require attachment of the DHMH 2989. The DHMH 2989-Sterilization Consent Form must be kept in the patient's Medical Record.

Hysterectomy:
U B04 claims reporting hysterectomy diagnosis or procedure codes do not require condition code reporting and do not require attachment of the DHMH 2990. The DHMH 2990 Document for Hysterectomy must be kept in the patient's Medical Record.

FL 29 **Accident State**

Not required. Report the two-digit state abbreviation when the services reported on this claim are related to an auto accident and the accident occurred in a country or location that has a state, province, or sub-country code named in X12 code source 22.

FL 30 **Reserved for Assignment by NUBC**

Not Used

FL 31-34 a b **Occurrence Codes and Dates**

Required when there is an Occurrence Code that applies to this claim. Enter the code and associated date defining a significant event relating to this bill that may affect payer processing. Enter all dates as MMDDYY.

The Occurrence Span Code fields can be utilized to submit additional Occurrence Codes when necessary by leaving the THROUGH date blank in FL 35-36. As a result, up to 12 Occurrence Codes may be reported.

Report Occurrence Codes in alphanumeric sequence (numbered codes precede alphanumeric codes) in the following order: FL 31a, 32a, 33a, 34a, 31b, 32b, 33b, 34b. If there are Occurrence Span Code fields available, fields 35a FROM, 36a FROM, 35b FROM and 36b FROM may then be used as an overflow. After all of these fields are exhausted, FL 81 (Code-Code field) can be used with the appropriate qualifier (A2) to report additional codes and dates (see FL 81 for additional information).

Enter the appropriate codes and dates from the table below.

Note A: Occurrence Codes should be entered in alphanumeric sequence. However, report any Occurrence Codes required to process your Maryland Medicaid claim first; then continue to report other Occurrence Codes as needed in alphanumeric sequence. Maryland Medicaid will only capture 12 Occurrence Codes, including those reported in FL 81.

Note B: Any hospital inpatient Type of Bill (TOB) with frequency codes 1or 4 must report occurrence Code 42 - Date of Death/Discharge.

Code Structure – Occurrence Codes & Dates:		
01	Accident/Medical Coverage	Code indicating accident-related injury for which there is medical payment coverage. Provide the date of accident/injury.
02	No Fault Insurance Involved – Including Auto Accident/Other	Code indicating the date of an accident including auto or other where the State has applicable no-fault liability laws (i.e., legal basis for settlement without admission of proof of guilt).
03	Accident/Tort Liability	Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related	Code indicating the date of an accident allegedly relating to the patient's employment.
05	Accident/No Medical or Liability Coverage.	Code indicating an accident related injury for which there is no medical payment or third-party liability coverage. Provide date of accident or injury.
06	Crime Victim	Code indicating the date on which a medical condition resulted from alleged criminal action committed by one or more parties.
09	Start of Infertility Treatment Cycle	Code indicating the date of start of infertility treatment cycle
10	Last Menstrual Period	Code indicating the date of the last menstrual period; ONLY applies when patient is being treated for maternity related condition.
11	Onset of Symptoms/Illness	Code indicating the date the patient first became aware of symptoms/illness.

Code Structure – Occurrence Codes & Dates:		
16	Date of last Therapy	Code denotes last day of therapy services (e.g., physical therapy, occupational therapy, speech therapy).
17	Date Outpatient Occupational Therapy Plan Established or Last Reviewed	Code denotes date an occupational therapy plan was established or last reviewed.
18	Date of Retirement Patient/ Beneficiary	The date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse	Code denotes the retirement date for the patient's spouse.
20	Date Guarantee of Payment Began	Code indicates date on which the provider began claiming Medicare payment under the guarantee of payment provision (see Medicare manual for special Medicare instructions).
21	Date UR Notice Received	Code indicating the date of receipt by the provider of the UR Committee's finding that the admission or future stay was not medically necessary.
22	Date Active Care Ended	Code indicates the date that covered level of care ended in a SNF or general hospital, the date on which active care ended in a psychiatric or tuberculosis hospital, or the date the patient was released on a trial basis from a residential facility. Code not required when Condition Code 21 is used.
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the hospital from any insurer.
25	Date Benefits Terminated by Primary Payer	Code indicating the date on which coverage (including Worker's Compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Became Available	Code indicating the date on which a SNF bed became available to hospital inpatient who requires only SNF level of care.
28	Date Comprehensive Outpatient Rehabilitation Plan Established or Last Reviewed	Code indicating the date a comprehensive outpatient rehabilitation plan was established or last reviewed.
29	Date Outpatient Physical Therapy Plan Established or Last Reviewed	Code indicating the date a physical therapy plan established or last reviewed.
30	Date Outpatient Speech Pathology Plan Established or Last Reviewed	Code indicated the date a speech pathology plan was established or last reviewed.
31	Date Beneficiary Notified of Intent to Bill (Accommodations)	The date of notice provided by the hospital to the patient that inpatient care is no longer required.
32	Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)	The date of notice provide to the beneficiary that requested care (diagnostic procedures or treatments) may not be reasonable or necessary.

Code Structure – Occurrence Codes & Dates:		
33	First Day of the Coordination Period for ESRD Beneficiaries Covered by EGHP	Code indicates the first day of coordination for benefits that are secondary to benefits payable under an employer's group health plan. Required only for ESRD beneficiaries.
34	Date of Election of Extended Care Facilities	Code indicates the date the guest elected to receive extended care services (used by Religious Non-Medical Only).
35	Date Treatment Started for Physical Therapy	Code indicates the initial date services by the billing provider for physical therapy began.
36	Date of Inpatient Hospital Discharge for Covered Transplant Patients	Code indicates the date of discharge for inpatient hospital stay in which the patient received a covered transplant procedure when the hospital is billing for immunosuppressive drugs. Note: When the patient received both a covered and a non-covered transplant, the covered transplant predominates.
37	Date of Inpatient Hospital Discharge for Non-covered Transplant Patient	Code indicates the date of discharge for the inpatient hospital stay in which the patient received a non-covered transplant procedure when the hospital is billing for immunosuppressive drugs.
38	Date Treatment Started for Home IV Therapy	Date the patient was first treated at home for IV therapy. (Home IV providers – Bill Type 085x).
39	Date Discharged on a Continuous Course of IV Therapy	Date the patient was discharged from the hospital on continuous course of IV therapy. (Home IV providers – Bill Type 085x).
40	Scheduled Date of Admission	The scheduled date the patient will be admitted as an inpatient to the hospital. (This code may only be used on an outpatient claim.)
41	Date of First Test Pre-Admission Testing	The date on which the first outpatient diagnostic test was performed as part of a PAT program. This code may only be used if a date of admission was scheduled before the administration of the test(s).
42	Date of Discharge	Use only when "Through" date in FL 6 (Statement Covers Period) is <u>not</u> the actual discharge date <u>and</u> the frequency code in FL 4 is that of a final bill (1 or 4).
43	Scheduled Date of Canceled Surgery	The date for which outpatient surgery was scheduled.
44	Date Treatment Started for Occupational Therapy	The date services were initiated by the billing provider for occupational therapy.
45	Date Treatment Started for Speech Therapy	The date services were initiated by the billing provider for speech therapy.
46	Date Treatment Started for Cardiac Rehabilitation	The date services were initiated by the billing provider for cardiac rehabilitation.

Code Structure – Occurrence Codes & Dates:		
47	Date Cost Outlier Status Begins	Code indicates that this is the first day after the day the Cost Outlier threshold is reached.
A1	Birth Date – Insured A	The birth date of the individual in whose name the insurance is carried.
A2	Effective Date – Insured A Policy	A code indicating the first date insurance is in force.
A3	Benefits Exhausted – Payer A *LTC Hospitals ONLY (i.e. Chronic)*	Enter the last date for which Medicare Part A benefits are available and after which no Medicare Part A payment can be made.
A4	Split Bill Date	Date patient became eligible due to medically needy spend down (sometimes referred to as "Split Bill Date").
B1	Birth Date – Insured B	The birth date of the individual in whose name the insurance is carried.
B2	Effective Date – Insured B Policy	A code indicating the first date insurance is in force.
B3	Benefits Exhausted – Payer B	Code indicating the last date for which benefits are available and after which no payment can be made by Payer B.
C1	Birth Date – Insured C	The birth date of the individual in whose name the insurance is carried.
C2	Effective Date – Insured C Policy	A code indicating the first date insurance is in force.
C3	Benefits Exhausted – Payer C	Code indicating the last date for which benefits are available and after which no payment can be made by Payer C.
DR		Reserved for Disaster Related Occurrence Code

FL 35-36a b **Occurrence Span Codes and Dates**

Required when there is an Occurrence Span Code that applies to this claim. These codes identify occurrences that happened over a span of time. Enter the code and associated beginning and ending dates defining a specific event relating to this billing period. Enter all dates as MMDDYY.

Report Occurrence Span Codes in alphanumeric sequence (numbered codes precede alphanumeric codes) in the following order: FL 35a & 36a, 35b & 36b. After all of these fields are exhausted, FL 81 (Code-Code field) can be used with the appropriate qualifier (A3) to indicate that Occurrence Span overflow codes are being reported. The third column in FL 81 is 12 positions, which accommodates both the FROM and THROUGH date in a single field (see FL 81 for more information).

Code Structure - Occurrence Span Codes and Dates:		
70	Qualifying Stay Dates For SNF Use ONLY	The from/through date of at least a 3-day inpatient hospital stay that qualifies the resident for Medicare payment of SNF services billed. Code can be used only by SNF for billing.
71	Prior Stay Dates	The from/through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit Dates	The from/through dates of outpatient services. For use on outpatient bills only where the entire billing record is not represented by the actual from/through service dates of FL 6 (Statement Covers Period).
73	Benefit Eligibility Period	The inclusive dates during which TRICARE medical benefits are available to a sponsor's beneficiary as shown on the beneficiary's ID card.
74	Non-Covered Level of Care/Leave of Absence Dates	The From/Through dates for a period at a non-covered level of care or leave of absence in an otherwise covered stay, excluding any period reported by Occurrence Span Code 76, 77, or 79 below.
75	SNF Level of Care Dates	The from/through dates of a period of SNF level of care during an inpatient hospital stay.
76	Patient Liability (Spend-down Amount Dates) **Replaces Code 80 as of 7/31/07**	The from/through dates for a period of non-covered care for which the hospital is permitted to charge the beneficiary. Enter the from/through dates indicated as the "begin" and "expiration" dates on the DHMH 4233, Notice of Eligibility letter. Indicate patient resources in FL 39-41 a,b,c, or d. Use **Value Code 66** and indicate the resource shown on the DHMH 4233, Notice of Eligibility letter
77	Provider Liability Period	The from/through dates of a period of non-covered care for which the provider is liable; utilization is charged.
78	SNF Prior Stay Dates	The from/through dates given by the patient of any SNF or nursing home stay that ended within 60 days of this hospital or SNF admission.
M0	QIO/UR Approved Stay Dates	The first and last days that were approved where not all of the stay was approved. (Use when Condition Code "C3" is used in FL 18-28 - enter the "from" and "through" dates of the approved billing period.)

Code Structure - Occurrence Span Codes and Dates:		
M1	Provider Liability- No Utilization	Code indicates the from/through dates of a period of non-covered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization.
M2	Inpatient Respite Dates	The from/through dates of a period of inpatient respite care.
M3	ICF Level of Care	The from/through dates of a period of intermediate level of care during an inpatient hospital stay.
M4	Residential Level of Care	The from/through dates of a period of residential level of care during an inpatient hospital stay.
MR	Reserved – Disaster Related	Reserved for Disaster Related Occurrence Span Code.

Code 74: • Code 74 is to be used by those Chronic, Psychiatric, Rehabilitation, and RTC providers for leave of absence (LOA) days non-covered by the Medicaid Program.
• If FL 35-36a,b equal 74, the occurrence code date span must equal only those dates non-covered. *FL 06 must include dates for both covered and non-covered days.*

Code 75: Code 75 = Administrative Days. Form DHMH 1288 is required.

FL 37 **NOT USED**

FL 38 **Responsible party name and address**

Not required. Used to print the name and mailing address of the party responsible for the bill if a window envelope is to be used.

FL 39-41 a-d Value Codes and Amounts

Required when there is a Value Code that applies to this claim. A code structure to relate amounts or values to data elements necessary to process this claim as qualified by the payer organization.

FLs 39a - 41a must be completed before the 'b' fields, etc. Whole numbers or non-dollar amounts are right justified to the left of the dollars/cents delimiter. Do not zero fill the positions to the left of the delimiter. Negative numbers are not allowed except in FL 41.

If all the Value Code fields are filled, use FL 81 Code-Code field with the appropriate qualifier code (A4) to indicate that a Value Code is being reported (see FL 81 for more information).

Note: Value Codes should be entered in alphanumeric sequence. However, report any Value Codes required to process your Maryland Medicaid claim first; then continue to report other Value Codes as needed in alphanumeric sequence. Maryland Medicaid will only capture 6 Value Codes, including those reported in FL 81.

Code Structure – Value Codes and Amounts:		
01	Most Common Semi-Private Rate	To provide for the recording of hospital's most common semi-private rate.
02	Hospital has no Semi-Private Rooms	Entering this code requires $0.00 amount.
06	Blood Deductible	Total cash blood deductible.
08	Life Time Reserve Amount in the First Calendar Year	Lifetime reserve amount charged in the year of admission.
09	Coinsurance Amount in the First Calendar Year	Coinsurance amounts charged in the year of admission.
10	Lifetime Reserve Amount in the Second Calendar Year	Lifetime reserve amount charged in the year of discharge where a bill spans two calendar years.
11	Coinsurance Amount in the Second Calendar Year	Coinsurance amount charged in the year of discharge where the inpatient bill spans two calendar years.
12	Working Aged Beneficiary/Spouse With Employer Group Health Plan	Amount shown reflects that portion of a payment from a higher priority employer group health insurance made on behalf of an aged beneficiary.
13	ESRD Beneficiary in a Medicare Coordination Period with an Employer Group Health Plan	Amount shown is that portion of a payment from a higher priority employer group Health insurance payment made on behalf of an ESRD beneficiary that the provider is applying to Medicare covered services on this bill.
14	No-Fault, Including Auto/Other	Amount shown is that portion from a higher priority no-fault insurance, including auto/other made on behalf of the patient or insured.
15	Worker's Compensation	Amount shown is that portion of a payment from a higher priority worker's compensation insurance made on behalf of the patient or insured. For Medicare beneficiaries the provider should apply this amount to Medicare covered services on this bill.
16	PHS, or Other Federal Agency	Amount shown is that portion of a payment from a higher priority Public Health Service or the Federal Agency made on behalf of a Medicare beneficiary that the provider is applying to Medicare covered services on this bill.
21	Catastrophic	Medicaid-eligibility requirements to be determined at a State level.
22	Surplus	Medicaid-eligibility requirements to be determined at a State level.
23	Recurring Monthly Income	Medicaid eligibility requirements to be determined at a State level.
30	Preadmission Testing	This code reflects charges for preadmission outpatient diagnostic services in preparation for a previously scheduled admission.

Code Structure – Value Codes and Amounts:		
37	Pints of Blood Furnished	The total number of pints of whole blood or units of packed red cells furnished to the patient, regardless of whether the hospital charges for blood or not.
38	Blood Deductible Pints	The total number of pints of whole blood or units of packed red cells furnished to the patient, regardless of whether the hospital charges for blood or not.
39	Pints of Blood Replaced	The total number of pints of whole blood or units of packed red cells furnished to the patient, regardless of whether the hospital charges for blood or not.
46	Number of Grace Days	Follows the date of the QIO determination. This is the number of days determined by the QIO (medical necessity reviewer) as necessary to arrange for the patient's post-discharge care.
66	Medicaid Spend Down Amount **Replaces Code D3 as of 7/31/07**	The dollar amount that was used to meet the recipient's spend down liability for this claim. For Maryland Medicaid inpatient only enter the amount of the patient's spend down amount as indicated on the DHMH 4233, Notice of Eligibility letter.
80[(a)]	Covered days	The number of days covered by the primary payer as qualified by the payer. Report days in the dollar amount field. DO NOT REPORT CENTS. See sample UB04 claim form for examples of correct and incorrect reporting.
81[(a)]	Non-Covered Days	Days of care not covered by the primary payer. Report days in the dollar amount field. DO NOT REPORT CENTS. See sample UB04 claim form for examples of correct and incorrect reporting.
82[(a)]	Co-insurance Days	The inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/ Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness. Report days in the dollar amount field. DO NOT REPORT CENTS.

Code Structure – Value Codes and Amounts:		
83[(a)]	Lifetime Reserve Days	Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness. Report days in the dollar amount field. DO NOT REPORT CENTS.
A1[(b)]	Deductible Payer A	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. *(Note: Report Medicare blood deductibles under Value Code 6).*
A2[(b)]	Coinsurance Payer A	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. *(Note: For Medicare, use this code only for reporting Part B coinsurance amounts. For Part A coinsurance amounts, use Value Codes 8-11.)*
A4	Covered Self Administrable Drugs – Emergency	The covered charge amount for self-administrable drugs administered to the patient in an emergency situation (e.g. diabetic coma). For use with Revenue Code 0637.
A5	Covered Self Administrable Drugs – Not Self Administrable in Form and Situation Furnished to Patient	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was not self-administrable in the form and situation in which it was furnished to the patient. For use with Revenue Code 0637.
A6	Covered Self Administrable Drugs – Diagnostic Study and Other	The amount included in covered charges for self-administrable drugs administered to the patient because the drug was necessary for diagnostic study or other reason (e.g., the drug is specifically covered by the payer). For use with Revenue Code 0637.
B1[(b)]	Deductible Payer B	The amount assumed by the provider to be applied to the patient's policy/program deductible amount involving the indicated payer. (Note: Medicare blood deductibles should be reported under Value Code 6).
B2[(b)]	Coinsurance Payer B	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. (For Part A coinsurance amounts, use Value codes 8-11).

Code Structure – Value Codes and Amounts:		
C1[(b)]	Deductible Payer C	The amount assumed by the provider to be applied to the patient's policy/program deductible amounts involving the indicated payer. (NOTE: Medicare blood deductibles should be reported under Value Codes 6.)
C2[(b)]	Coinsurance Payer C	The amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer. (For Part A coinsurance amounts, use Value codes 8-11).
D3	Patient Estimated Responsibility	The amount estimated by the provider to be paid by the indicated patient.

[(a)] *Do not use on v. 004010/004010A1 837 electronic claims (use Claim Quantity in Loop ID 2300 | QTY01 instead). For v. 005010, this information should be sent in the Value Codes HI segment as defined in the Health Care Claim: Institutional (837)TR3.*

[(b)] *This code is to be used only on paper claims. For electronic 837 claims, use Loop ID 2320 | CAS segment (Claim Adjustment Group Code "PR").*

Note: Codes 80 & 81 must be submitted showing the number of covered and non-covered days when you are billing a partial approved inpatient claim.

FL 42 Revenue Codes

Required. Line 1-23. Enter the appropriate four-digit numeric revenue code from the enclosed Revenue Code Matrix to identify specific accommodation and/or ancillary charges.

On a multiple page UB04, all of the claim level information is repeated on each page; only the line items in the revenue code section will vary. The 23rd line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

The appropriate revenue code must be entered to explain each charge in FL 47.

- For inpatient services involving multiple services for the same item providers should combine the services under the assigned revenue code and then report the total number of units that represent those services.
- For outpatient services providers should report the corresponding HCPCS code for the service along with the date of service and the revenue code. HCPCS are required only for those outpatient revenue codes listed under FL 44.
- If multiple services are provided on the same day for like services, that is, those with the same revenue code, the provider should combine the like services for each day and report the rate along with the number of units provided.

To assist in bill review, revenue codes should always be listed in ascending numeric sequence, by date of service (outpatient). The exception is Revenue Code 0001, which is used on paper claims only and is reported on Line 23 of the last page of the claim. On inpatient claims, accommodations must be entered first on the bill and in revenue code sequence. Revenue codes must not be repeated on the same bill.

NOTE: Detail beyond 0 level code in fourth digit field is not required unless specified in the **Revenue Code Matrix Table**, which you will find included in these Instructions.

FL 43 National Drug Code (NDC) - Medicaid Drug Rebate Reporting

Required - on outpatient and inpatient claims.

NOTE: These instructions detail only those data elements required for Medical Assistance (MA) paper claim billing. For electronic billing, please refer to the Maryland Medicaid 837-I Electronic Companion Guide, which can be found on our website:
http://mdh.maryland.gov/hipaa/transandcodesets.html

Format

1) Report **the NDC Qualifier** of "N4" in the first two (2) positions, left justified
2) Followed immediately by **the 11-Character NDC Number** in the 5-4-2 format **(**do not report hyphens**).**
3) Followed immediately by **the Unit of Measurement Qualifier** (listed below).
   F2 -International Unit
   GR-Gram
   ME-Milligram
   ML-Milliliter
   UN- Unit
4) Followed immediately by **the Unit Quantity** with a floating decimal for fractional units limited to three (3) digits to the right of the decimal point. Any spaces unused for the quantity field are left blank.
   Notes:
   - Enter the actual metric decimal quantity (units) administered to the patient.
   - A maximum of seven (7) positions to the left of the floating decimal may be reported.
   - When reporting a whole number, do not key the floating decimal.
   - When reporting fractional units, you must enter the decimal as part of the entry.

Sample NDC:

Whole Number Unit:

N	**4**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**0**	**1**	**U**	**N**	**1**	**2**	**3**	**4**	**5**	**6**	**7**				

Fractional Unit:

N	**4**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**0**	**1**	**U**	**N**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**.**	**1**	**2**	**3**

General NDC Reporting Notes:

1) If the NDC reported is not eligible for the rebate, the line item charges will be denied by Maryland Medicaid.
2) Do not enter a revenue code description in the field.
3) Do not enter a space between the qualifier and NDC.
4) Do not enter hyphens or spaces within the NDC number.
5) The NDC number submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.
6) Enter the NDC unit of measurement code and numeric quantity administered to the patient.
7) The Description Field on the UB04 is 26-characters in length (refer to the sample NDC above).

Reporting Multiple NDC's

You may report multiple line items of revenue codes and NDC codes within series 025X or revenue code 0637, following the guidelines below:

1) Each line item must reflect a revenue code within series 025X or revenue code 0637.
2) Each line item must reflect a valid NDC per the NDC format.
3) Each NDC reported must be unique or the revenue code line item will deny as a duplicate against the Revenue Code and NDC line item that matches it.

Effective May 1, 2015, the Medical Assistance Program will require 340B designated hospitals to use the National Drug Code (NDC) on outpatient claims for bill types 131 and 135 when billing revenue codes 0250,0251,0252,0257,0258,0258,0636 and 0637. This implementation date is specific for claims submitted for payment on or after May 1, 2015 regardless of date of service.

Reporting Compound Drugs

When reporting compound drugs, a maximum of 5 lines are allowed.

Line 1: Report the revenue code, NDC, HCPCS, and sum the total units and total charges for all line items included in the compound drug.

Lines 2-4: Report only the NDC and HCPCS correlating to the compound drug.

Example

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0250	N412345678901UN1234567	HCPCS		SUM UNITS	SUM CHARGES		
	N498765432101UN7654321	HCPCS					
	N400011122201UN1234567	HCPCS					
	N433344455501UN349	HCPCS					
	N477788899901UN1.12	HCPCS					
	PAGE OF	CREATION DATE		TOTALS			

FL 44 **HCPCS/Accommodation Rates/HIPPS Rate Codes**

Required for outpatient billing only. The field contains 5 positions for the base code, plus 8 positions for up to 4 HCPCS modifiers and must be submitted in the following circumstances:

HCPCS:
When the following surgical revenue codes listed below are billed:

Revenue Codes: 0360, 0361, 0490, 0499, 0750, & 0790.

HIV Testing: (MCO Carve-out Services)
To receive fee-for-service payment for the following HIV testing services, you must submit Revenue code 0306 with the following HCPCS code/diagnosis code combinations. Revenue code 0306 is the only revenue code that can be submitted for HIV testing.

HIV Testing (MCO Carve-Out Services) Outpatient Billing		
Revenue Code	**HCPCS Code**	**Diagnosis Code**
0306	87536	V08 042 V01.79 (Age restricted under 1 year)
0306	87900	042
0306	87901	042 V08
0306	87903	042
0306	87904	042

Audiology-Related Services: The corresponding HCPCS codes are required when billing Revenue Codes in the 047x series to indicate that a surgery for a cochlear implant or osseointegrated device was performed. See page 7-8 for further instructions.

HCPCS Modifiers:
Not required. Modifiers can clarify or improve the reporting accuracy of the associated procedure code.

Accommodation Rates:
Not required. Enter the accommodation rate for inpatient bills.

HIPPS:
Not required. HIPPS rate codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several prospective payment systems.

FL 45 **Service Date**

Line 1-22: Not required. Enter the date (MMDDYY) the outpatient service was provided.

Line 23: Enter Creation Date (MMDDYY)

Required. Enter the date the bill was created or prepared for submission. Creation Date on Line 23 should be reported on all pages of the UB04.

FL 46 **Units of Service**

Required. Enter the total number of ***covered*** accommodation days, ancillary units of service, or visits, where appropriate and defined by revenue code requirements. There must be a unit of service for every revenue code except 0001.

Note: Units of service must include the total of **both covered and non-covered services** when you are billing total covered and non-covered charges in FL 47, such as hospital day limits of uncompensated care.

FL 47 **Total Charges**

Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period (FL 06). Total charges include both covered and non-covered charges.

Line Item Charges
Required - Lines 1-22. Line items allow up to nine numeric digits (0,000,000.00); 7 positions for dollars, 2 positions for cents.

Total (Summary) Charges
Required - Line 23 of the final claim page using Revenue Code 0001.

The 23rd line contains an incrementing page count and total number of pages for the claim on

each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

(Revenue code 0001 is not used on electronic transactions; report the total claim charge in the appropriate data segment/field according to the electronic companion guides).

NOTE A: Your facility may opt to bill only covered charges, except for hospitals billing for hospital day limit uncompensated care.

NOTE B: Newborn charges must be billed separately under the newborn's Medical Assistance Number.

FL 48 **Non-Covered Charges**

To reflect the non-covered charges as they pertain to the related revenue code.

Line Item Non-Covered Charges
Required – Lines 1-22 if needed to report line specific non-covered charge amounts. Line items allow up to nine numeric digits (0,000,000.00); 7 positions for dollars, 2 positions for cents.

Total (Summary) Non-Covered Charges
Required - Line 23 of the final claim page using Revenue code 0001 when there are non-covered charges on the claim.

The 23rd line contains an incrementing page count and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

(Revenue code 0001 is not used on electronic transactions; report the total claim charge in the appropriate data segment/field according to the electronic companion guides).

All charges in FL 48 will be subtracted from total charges in FL 47.

NOTE: If your facility has opted to bill only covered charges in FL 47 then this column will be blank. This column should not be blank for hospitals billing for hospital day limit uncompensated care.

FL 49 **Reserved for Assignment by NUBC**

NOT USED

FL 50 a,b,c **Payer Name**

Optional.

First line, 50a is the Primary Payer Name.
Second line, 50b is the Secondary Payer Name.
Third line, 50c is the Tertiary Payer Name.

Multiple payers should be listed in priority sequence according to the priority in which the provider expects to receive payment from these payers.

Note: If other payers listed, Medicaid should be the last entry in this field.

FL 51 a,b,c **Health Plan Identification Number**

Not required. When other health plans are know to potentially be involved in paying this claim. The number used by the health plan to identify itself. Report the HIPAA National Plan Identifier when it becomes mandated; otherwise report the (legacy/proprietary) number (i.e., whatever number used has been defined between trading partners).

FL 52 a,b,c **Release of Information Certification Indicator**

Not required. Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization).

Code Structure – Release of Information Certification Indicator

		Usage Note
X	Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes	Required when the provider has not collected a signature and state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.
Y	Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim	Required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring a signature be collected.

FL 53 a,b,c **Assignment of Benefits Certification Indicator**

Not required. Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.

N No
W Not Applicable (Use code 'W' when the patient refuses to assign benefits.)
Y Yes

FL 54 a,b,c **Prior Payments - Payer**

Required when the indicated payer has paid an amount to the provider towards this bill. Enter the amount the provider has received (to date) by the health plan toward payment of this bill. DO NOT REPORT MEDICARE PRIOR PAYMENTS IN THIS FIELD.

FL 55 a,b,c **Estimated Amount Due**

Not required. When the provider estimates an amount due from the indicated payer (estimated responsibility less prior payments).

FL 56 **National Provider Identifier (NPI) – Billing Provider**

Required. The unique identification number assigned to the provider submitting the bill; NPI is the 10-digit national provider identifier. Beginning on the Medical Assistance NPI compliance date of July 30, 2007, when the Billing Provider is an organization health care provider, the organization health care provider will report its 10-digit NPI or its subpart's NPI in FL 56.

Note: Organizational health care providers must continue to report proprietary legacy identifiers necessary for Maryland Medicaid to identify the Billing Provider entity in FL 57 Lines a-c.

FL 57 a,b,c **Other (Billing) Provider Identifier - Legacy**

Required. A unique identification number assigned to the provider submitting the bill by the health plan. Enter the Maryland Medicaid Legacy 9-digit provider number.

FL 58 a,b,c **Insured's Name**

Not required. The name of the individual under whose name the insurance benefit is carried.

FL 59 a,b,c **Patient Relationship to Insured**

Not required. Code indicating the relationship of the patient to the identified insured.

Code	Title
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

FL 60 a,b,c **Insured's Unique ID**

Required. Enter the 11-digit Medical Assistance number of the insured as it appears on the Medical Assistance card. If billing for a newborn, you must use the newborn's Medical Assistance number.

If there are other insurance numbers shown, such as Medicare, then the Medicaid identification number should appear last in the field.

REMINDER:

Providers may verify a patient's current Medical Assistance eligibility by calling the Eligibility Verification System/Interactive Voice Response (EVS/IVR) line:

Toll-Free Number for the entire State: **1-866-710-1447**

WebEVS: Providers may verify a patient's current Medical Assistance eligibility by using the new web-based eligibility services available for providers who are enrolled in EMedicaid. To access this service, click on: www.emdhealthchoice.org

FL 61 a,b,c **Insured's Group Name**

Not required. The group or plan name through which the insurance is provided to the insured.

FL 62 a,b,c **Insured's Group Number**

Not required. When the insured's identification card shows a group number. The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.

FL 63 a,b,c **Treatment Authorization Code**

Required for inpatient billing only and only when the MDH 3808 document is required. Enter the 8-digit UB04 3808 Document Number as obtained from the Utilization and Control Agent.

FL 64 a-c **Document Control Number (DCN)**

FUTURE USE. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Required when Type of Bill Frequency Code (FL 04) indicates this claim is a replacement or void to a previously adjudicated claim.

FL 65 **Employer Name (of the Insured)**

Not required. The name of the employer that provides health care coverage for the insured individual identified in FL 58.

FL 66 **Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**

Not Required. The qualifier that denotes the version of International Classification of Diseases (ICD) reported.

FL 67 **Principal Diagnosis Code and Present on Admission Indicator**

Principal Diagnosis Code

Required. Enter the 5-digit ICD-10-CM code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for occasioning the admission of the patient for care).

Always code to the most specific level possible, but do not enter any decimal points when recording codes on the UB-04.

Follow the official guidelines for ICD reporting. Refer to the Official ICD-10-CM Guidelines for Coding and Reporting for additional information.

The ICD-10-CM codes will be used for inpatient and outpatient services.

NOTE A: The principal diagnosis code will include the use of "V" codes. The "E" codes are not acceptable for principal diagnosis.

NOTE B: When billing for newborn, must use newborn diagnosis codes.

Present on Admission (POA) Indicator – **Not Required: All Fields**

- The 8th digit of FL 67 - Principal Diagnosis (shaded area), and each of the secondary diagnosis fields (FL 67A-Q).
- The 8th digit of FL 72, External Cause of Injury (ECI) (3 fields on the form).

FL 67 a-q **Other Diagnosis Codes**

Required. Enter the 5-digit ICD-10-CM diagnoses codes corresponding to all conditions that co- exist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Exclude diagnoses that relate to an earlier episode which have no bearing on the current hospital stay.

Enter the appropriate ICD-10-CM diagnosis code (co-morbidity) in FL 67a that determines the DRG selected.

Completion of FL 67 c-q are currently optional as our data processing system will accept one principal and three co-existing diagnoses.

NOTE A: Other diagnoses codes will permit the use of "V" codes and "E" codes where appropriate.

NOTE B: For the 3808, the principal and 1st secondary diagnosis should be what determines the DRG. When billing, UB-04 diagnosis codes must sequentially match the 3808.

FL 68 **Reserved for Assignment by NUBC**

NOT USED

FL 69 **Admitting Diagnosis**

Not required. Enter the ICD diagnosis code describing the patient's diagnosis at the time of admission.

The ICD-10-CM diagnosis code describing the admitting diagnosis as a significant finding representing patient distress, an abnormal finding on examination, a possible diagnosis based on significant findings, a diagnosis established from a previous encounter or admission, an injury, a poisoning, or a reason or condition (not an illness or injury) such as follow-up or pregnancy in labor. Report only one admitting diagnosis.

FL 70 a,b,c **Patient's Reason for Visit Code**

Not required. The ICD-10-CM diagnosis codes describing the patient's reason for visit at the time of outpatient registration.

An "unscheduled" outpatient visit is defined as an outpatient Type of Bill 013X together with Form Locator 14 (Priority Type of Visit) codes 1, 2 or 5 and Revenue Codes 045X, 0516, 0526, or 0762 (Observation Room).

FL 71 **Prospective Payment System (PPS) Code**

Required. The PPS code (3-digit DRG Code) assigned to the claim to identify the DRG based on the grouper software called for under contract with the primary payer.

FL 72 a-c **External Cause of Injury Code (ECI)/POA Indicator**

Not required. When an injury, poisoning or adverse effect is the cause for seeking medical treatment or occurs during the treatment. ECI codes begin with V,W, X, or Y in ICD-10-CM. ECI codes cannot be principal diagnoses on claims or preauthorizations. POA indicated not required.

Priority for reporting ECI code in FL 72 a-c:

- Principal diagnosis of an injury or poisoning
- Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis.
- Other diagnosis with an external cause.

FL 73 **Reserved for Assignment by NUBC**

NOT USED

FL 74 **Principal Procedure Code and Date**

Required on inpatient claims when a procedure is performed. When determining which of the several procedures is the principal procedure; the following criteria should be applied in sequence.

a. The principal procedure is one which was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes or was necessary to take care of a complication; or
b. The principal procedure is that procedure most related to the principal diagnosis.

This code structure must be ICD-10-CM when billing inpatient services. Whenever a procedure is provided a date must be supplied - format is "MMDDYY".

This date must fall between the "From" and "Through" dates reported in FL 6, except for claims with a Type of Bill Frequency Code of 3 or 4.

NOTE: **Not required on outpatient claim submissions as of 2/13/12.**

FL 74 a-e **Other Procedure Codes and Dates**

Required on inpatient claims when additional procedures must be reported. Enter the ICD codes identifying all significant procedures, other than the principal procedure, and the dates on which the procedures were performed during the billing period covered by this bill. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis. Procedure codes must sequentially match 3808.

This code structure must be ICD-10-CM when billing inpatient or outpatient services.

Whenever a procedure is provided, a date must be supplied, format is "MMDDYY". Completion of FL 74 c-e is optional as our data processing system will only accept the principal code and date and two additional procedure codes and dates.

Date(s) must fall between the "From" and "Through" dates reported in FL 6, except for claims with a Type of Bill Frequency Code of 3 or 4.

NOTE: **Not required on outpatient claim submissions as of 2/13/12.**

FL 75 **Reserved for Assignment by NUBC**

NOT USED

FL 76 **Attending Provider Name and Identifiers**

Required. The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim.

Line 1 Inpatient: **Required.** Enter the 10-digit NPI number assigned to the physician attending

an inpatient. This is the physician primarily responsible for the care of the patient from the beginning of this hospitalization.

Line 1 Outpatient: **Required.** Enter the 10-digit NPI number assigned to the physician referring the patient to the hospital. When a patient is not referred or has no private physician, the attending physician is the staff member to whom the patient is assigned.

Line 1 Secondary Identifier Qualifiers: **Required**

Enter the Attending Physician's 9-digit Maryland Medicaid Provider Number.

Note: If the Attending Physician's 9-digit Maryland Medicaid Provider number is not known/unavailable, enter "999995700".

Line 2 Attending Physician Name
Not required. Last name, First name

FL 77 Operating Physician Name and Identifiers

Required when a surgical revenue code is listed on this claim. Enter the name and identification number of the individual with primary responsibility for performing surgical procedure(s).

Line 1 Inpatient: **Required.** Enter the 10-digit NPI number assigned to the operating physician who performed the principal procedure, if any.

Line 1 Outpatient: **Required.** Enter the 10-digit NPI number assigned to the operating physician who performed the principal procedure, if any.

Line 1 Secondary Identifier Qualifiers: **Required**
Enter the Attending Physician's 9-digit Maryland Medicaid Provider Number.
Note: If the Attending Physician's 9-digit Maryland Medicaid Provider number is not known/unavailable, enter "999995700".

Line 2 Operating Physician Name
Not required. Last name, First name

FL 78 & 79 **Other Provider (Individual) Names and Identifiers**

Not required. Enter the name and ID number of the individual corresponding to the Provider Type category indicated below.

Line 1:

Provider Type Qualifier Codes:

DN	Referring Provider	The provider who sends the patient to another provider for services. Required on outpatient claims when the Referring Provider is different than the Attending Physician.

ZZ	Other Operating Physician	An individual performing a secondary surgical procedure or assisting the Operating Physician. Required when another Operating Physician is involved.
82	Rendering Provider	The health care professional who delivers or completes a particular medical service or non-surgical procedure. Report when state or federal regulatory requirements call for a combined claim; i.e., a claim that includes both facility and professional fee components.

Line 1 Inpatient: Enter the 10-digit NPI number assigned to the other provider.

Line 1 Outpatient: Enter the 10-digit NPI assigned to the other provider.

Line 1 Secondary Identifier Qualifiers: Not required
Enter the Attending Physician's 9-digit Maryland Medicaid Provider Number.
Note: If the Attending Physician's 9-digit Maryland Medicaid Provider number is not known/unavailable, enter "999995700".

Line 2: Enter Other Provider Name:
Not required. Last name, First name

FL 80 Remarks

Not required. Area to capture additional information necessary to adjudicate the claim.

FL 81 a-d Code-Code Field

Situational. To report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set.

Where applicable, providers should use taxonomy codes as noted.

Left Column:	Middle Column:	Right Column:
1 field (Code Qualifier)	1 field (Code)	1 field (Number or Value)

Notes

Code List Qualifiers:

01-A0 Reserved for National Assignment

A1 National Uniform Billing Committee Condition Codes (FL 18-28)
Right column is blank.

Example:

A	1	4	4																				

A2 National Uniform Billing Committee Occurrence Codes (FL 31-34)

Example:

A	2	0	1															0	2	2	8	0	6

A3 National Uniform Billing Committee Occurrence Span Codes (FL 35-36)
All positions fully coded in the right column.

Example:

A	3	M	4									0	3	0	1	0	6	0	3	0	9	0	6

A4 National Uniform Billing Committee Value Codes (FL 39-41)
For Value Codes, there is an implied dollar/cents delimiter in the right column of FL 81 separating the last two positions as illustrated below.

												$	$	$	$	$	$	$	$	$	$	c	c

See FL 39-41 for special rules for reporting values. Whole numbers or non-dollar amounts are right justified to the left of the implied dollars/cents delimiter. Do not zero fill the positions to the left of the implied delimiter. However, values are reported as cents, thus reference to the instructions for specific codes is necessary.

Example:

A	4	5	4															3	3	3	3		

A5-B0 Reserved for Assignment by the NUBC.

B1 Standards for the Classification of Federal Data on Race and Ethnicity
Code Source: ASC X12 External Code Source 859 (Health Information and Surveillance Systems Board)

Reporting*
FOR PUBLIC HEALTH DATA REPORTING ONLY when required by state or federal law or regulations.

Example:

B	1	R	5	E	5																		

B3 **Required.** Health Care Provider Taxonomy Code.

Used for Billing Provider only. For provider types listed below, use the taxonomy code accompanying your specialty. You must submit the accompanying designated taxonomy code listed below to assure appropriate reimbursement from the Medical Assistance Program.

Medicaid Provider Specialty/Taxonomy Code Table			
Specialty	**Bill Type(s)**	**Subspecialties**	**Taxonomy Code**
Acute General Hospital	IP: **111,** 112, 113, 114, 115, 121 OP: **131**, 135	Only the acute hospital taxonomy code should be billed on an acute hospital claim.	282N00000X
Acute Rehabilitation Hospital	IP: **111,** 112, 113, 114, 115 OP: **131**, 135	Medicaid Stand-Alone Rehab Hospital	283X00000X
Acute Rehabilitation Hospital	IP: **111,** 112, 113, 114, 115 OP: **131**, 135	Medicaid General Acute Hospital with Rehab Unit	273Y00000X
Chronic Rehabilitation Hospital	IP: **151,** 152, 153, 154, 155		282E00000X
Chronic Hospital	IP: **151,** 152, 153, 154, 155		281P00000X
Special Other Acute Hospitals	IP: **111,** 112, 113, 114, 115 OP: **131**, 135	Pediatric Inpatient	282NC2000X
Special Other Chronic Hospitals	IP: **151,** 152, 153, 154, 155	Pediatric Inpatient	281PC2000X
Nursing Facility	211, 212, **213**, 214		314000000X
ICF-Addictions	IP: **651,** 652, 653, 654, 655	Substance Disorder	324500000X

All positions fully coded in the middle column; the right-hand column is left blank.

Example:

B	3	2	8	2	N	0	0	0	0	0	X												

UB04 Hospital
Addendum Instructions
Administrative Day Billing

COMPLETION OF UB-04 FOR HOSPITAL INPATIENT ADMINISTRATIVE DAY SERVICES

The following instructions are specific to billing for administrative days and address only key problematic areas. They should be used in conjunction with the standard UB04 billing instructions. They apply to all hospitals with exception to general hospitals in prospective payment states.

Administrative day charges should be billed on a separate UB04 form with the approved DHMH 1288 or DHMH 1288A form attached. All days and services unrelated to the administrative days will continue to be billed as previously instructed. No other room and board codes or ancillary codes can be billed during the administrative day stay.

The DHMH 1288 "Report of Administrative Days" form is to be used by all hospitals, except psychiatric hospitals, which must use the form DHMH 1288A. Psychiatric hospitals must ensure that the hospital's utilization review committee signs and dates the form 1288A. The "Report of Administrative Days" form must be attached to the invoice.

SPECIAL NOTE: As a result of the way our system discounts your entire bill, it is very important that the instructions for determining the amount to be billed (Item 47) be followed exactly.

The Maryland Medicaid statute of limitations for timely claim submission is set forth in the introduction pages of this billing manual and must be adhered to when submitting administrative day claims.

Completed invoices must be sent via paper submission with required DHMH 1288 attachment to the following address:

Maryland Medical Assistance Program
Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203

Billing Provider Name and Address

2 ICN – **Leave Blank**

3a PAT. CNTL # Patient Control Number

4 TYPE OF BILL 1XX

b. MED. REC. #

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM THROUGH Admin Service Dates

7

8 PATIENT NAME a

9 PATIENT ADDRESS a

b Patient Nam : ast Name, First

b c d e

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

Report hen a

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 75 rom Through

b

38

Correct per UB04 Instructions = 5 days ¢
(Acceptable = 5 days) ¢

(Not correct = 500 da s) ¢

39 VALUE CODES CODE AMOUNT 40 VALUE CODES CODE AMOUNT 41 VALUE CODES CODE AMOUNT

a 80

b 80 00 5

c

d 80 5

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0169	Admin Day			Cov'd Admin Days	Total Admin Charges		
23	PAGE OF	CREATION DATE	Create Date	TOTALS			

50 PAYER NAME 51 HEALTH PLAN ID 52 REL INFO 53 ASG. BEN. 54 PRIOR PAYMENTS 55 EST. AMOUNT DUE 56 NPI NPI Number

When applicable

57 OTHER PRV ID Medicaid Legacy 9-digit Provider #

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

Patient's Medical Assistance ID
*Should always be last entry in field

63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME

DHM 3808 Document Number (if applicable)

66 DX 67 A B C D E F G H 68

required Optional

Optional Optional Optional

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

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

Required in- patient claims ONLY

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

Optional

76 ATTENDING NPI NPI required QUAL MA 9-digit Prov

LAST FIRST

77 OPERATING NPI NPI required QUAL MA 9-digit Prov

LAST FIRST

78 OTHER NPI QUAL

LAST FIRST

79 OTHER NPI QUAL

LAST FIRST

80 REMARKS

Not Required - Optional

81CC a B3 Taxonomy Code

b Other Codes When Applicable

c

d

UB-04 CMS-1450 OMB APPROVAL PENDING

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NUBC National Uniform Billing Committee LIC9213257

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

FL 04 **Type of Bill**

Type of Bill Do NOT report leading zero	Description	Inpatient/Outpatient General Designation
011x	Hospital Inpatient (including Medicare Part A)	IP
015x	Chronic Hospitals, Chronic Rehabilitation Hospitals, Specialty Chronic Hospitals	IP

Type of Bill Frequency Codes:		
3	Interim Billing- Continuing Claim	This code is to be used when a bill for the same confinement or course of treatment has previously been submitted and it is expected that further bills for the same confinement or course of treatment will be submitted for which payment is expected from the payer. FL 17 should equal "30".
4	Interim Billing - Last Claim	This code is to be used for the last (discharge) of a series of bills for the same confinement or course of treatment for which payment is expected from the payer.

FL 06 **Statement Covers Period (From - Through)**

Required. Enter the "From" and "Through" dates covered by the service for administrative days only. Remember that Medical Assistance does not pay for accommodations for the date of death/discharge. The date of death/discharge should never be shown as the through date in this field.

NOTE A: "Split" billing. An acute care hospital may not "split" a Medical Assistance bill except for the conditions listed below. The exceptions are:

- Administrative Days must be billed separately from acute hospital days. The DHMH-1288 form, Report of Administrative Days, must be attached.

FL 35-36a b **Occurrence Span Codes and Dates**

Required when there is an Occurrence Span Code that applies to this claim. These codes identify occurrences that happened over a span of time. Enter the code and associated beginning and ending dates defining a specific event relating to this billing period. Enter all dates as MMDDYY.

Code Structure - Occurrence Span Codes and Dates:		
75	SNF Level of Care Dates	The from/through dates of a period of SNF level of care during an inpatient hospital stay.

Code 75: Code 75 = Administrative Days. Form DHMH 1288 is required.

FL 39-41 a-d Value Codes and Amounts

Required when there is a Value Code that applies to this claim. A code structure to relate amounts or values to data elements necessary to process this claim as qualified by the payer organization.

FLs 39a - 41a must be completed before the 'b' fields, etc. Whole numbers or non-dollar amounts are right justified to the left of the dollars/cents delimiter. Do not zero fill the positions to the left of the delimiter. Negative numbers are not allowed except in FL 41.

Note: Value Codes should be entered in alphanumeric sequence. However, report any Value Codes required to process your Maryland Medicaid claim first; then continue to report other Value Codes as needed in alphanumeric sequence. Maryland Medicaid will only capture 6 Value Codes, including those reported in FL 81.

Code Structure – Value Codes and Amounts:		
80[(a)]	Covered days	The number of days covered by the primary payer as qualified by the payer. Report days in the dollar amount field. DO NOT REPORT CENTS. See sample UB04 claim form for examples of correct and incorrect reporting.

[(a)] *Do not use on v. 004010/004010A1 837 electronic claims (use Claim Quantity in Loop ID 2300 | QTY01 instead). For v. 005010, this information should be sent in the Value Codes HI segment as defined in the Health Care Claim: Institutional (837)TR3.*

Note: Enter only the number of days approved for "administrative days" that are covered by the Medicare Assistance Program.

FL 42 **Revenue Codes**

Use revenue code 0169 for DOS 11/1/2009 forward. This revenue code is specific to administrative days.

For DOS prior to 11/1/2009, use revenue code 0109.

NOTE: This is the only revenue code to be shown on this invoice other than the total charge revenue code of 0001. **Ancillary revenue codes/services cannot billed during an administrative day period.**

FL 46 **Units of Service**

Required. Enter the number of approved administrative days on the line adjacent to revenue code 0169. There must be a unit of service for every revenue code except 0001.

FL 47 **Total Charges**

As previously noted, it is very important that the following instructions for determining the amount to be billed be followed exactly.

A. In order to be paid correctly, hospitals without a licensed skilled nursing facility unit must divide the "projected average Medicaid nursing home payment rate" (Administrative Day Rate) by your rate of reimbursement.

   Example 1
   Maryland general acute and chronic hospitals are paid 94% of total charges. Divide the appropriate Administrative Day Rate by 94%. Multiple that result times the number of administrative days to yield the amount to be billed in Item 47.

   Example 2
   DC general hospitals and some other out-of-state general hospitals are paid a percentage of total charges. If their percentage reimbursement rate is 80% the facility would divide the appropriate Administrative Day Rate by 80%. Multiple that result times the number of administrative days to yield the amount to be billed in item 47.

   Example 3
   Hospitals paid on a per diem basis will bill the Program the appropriate Administrative Day Rate times the number of administrative days since their rate of reimbursement is actually 100% of the administrative day charges. This pertains to some out-of-state general hospitals and out-of-state special rehabilitation hospitals. Psychiatric hospitals should use the appropriate average residential treatment center rate (Administrative Day Rate for Special-Psychiatric Hospitals).

B. With the exception of psychiatric facilities, hospitals with a licensed skilled nursing facility must charge the lesser of the appropriate Administrative Day Rate or the allowable costs in effect under Medicare for extended care services provided to patients of such unit.

Administrative Day Rate Transmittals may be found on the web at the following address:
http://www.mdh.state.md.us/mma/MCOupdates/index.html

UB04 Hospital
Addendum Instructions
Out-of-State Hospital Billing

Effective 10/1/09

COMPLETION OF UB-04 FOR OUT-OF-STATE HOSPITAL SERVICES

The instructions below have been written in the interest of assisting out-of-state acute general hospitals understand Maryland's reimbursement methodology. **This addendum is an overview of problematic areas on the UB04 that cause the most difficulty for out-of-state providers when submitting the UB04 claim form to Maryland Medicaid.** It is by no means all-inclusive and claim submissions must adhere to the complete UB04 Hospital Billing Instruction Manual. When submitting electronic claims, adhere to the requirements in this manual and correlate the paper form locators to appropriate 837-I loops and segments.

Inpatient claims are subject to an Admission and Length of Stay medical review by Maryland's Utilization Control Agent (UCA). For more information on Maryland's current UCA, refer to Hospital Transmittal #210 located on our website at the following address:

http://www.mdh.state.md.us/mma/trans/FY11/PT14-11.pdf

Based on COMAR regulations, the Medicaid Program is mandated to pay the lesser of total charges or the rate developed by the state in which the hospital is located. In order to do that, and to allow hospitals out of the state of Maryland to submit claims electronically, the Medicaid Program has developed the following process:

For claims reflecting dates of service on or after October 1, 2009, the Program will require that out of state hospitals submit claims with total charges reflecting the reimbursement rate that would have been paid by their state Medicaid program for that hospital stay; or the hospital's actual total charges, whichever is the lesser amount. The Maryland Medicaid Program will reimburse summary line total charges from out of state hospitals at 100% of the charged amount.

Please refer to the memorandum from the Program dated 9/28/2009 for more detailed information regarding the rate process. You will find the memorandum at the end of this addendum. Please refer any questions about payment rates to the Office of Health Services at 410-767-1722. Please refer any billing questions regarding the format and submission of claims, claim status, or error resolution to Institutional Services Hotline at 410-767-5457.

Claims for dates of service prior to 10/1/09 will continue to be priced based on paper submission of an itemized UB04 claim billed under actual hospital total charges. Host state rates must be attached for manual pricing. Please note: Any inpatient claim with an admit date prior to 10/1/09, but with a discharge after 10/1/09 should be submitted via paper as noted above, with rate attachments for pricing.

FL 06 **Statement Covers Period (From - Through)**

Enter only those "From" and "Through" dates covered by the services on the invoice (MMDDYY). The "Through" date equals the date through which we are paying for accommodations.

- Remember that Medical Assistance does not pay for accommodations for the date of death/discharge. The date of death/discharge should never be shown as the through date in this field.
- There can only be one date of service reported per outpatient invoice. Date ranges are not acceptable unless billing Medicare coinsurance with the Medicare EOMB attached.

FL 08a **Patient Name – Identifier**

The name reported in this field must match the name on the Medical Assistance card (Last, First). You must bill a child or newborn's account using its own name and Medical Assistance number.

FL 31-34 **Occurrence Codes and Dates**

The discharge code and date must be reported in this field for inpatient claims. Refer to detailed instructions to obtain discharge code and third party liability override codes.

FL 39-41 **Value Codes and Amounts**

Refer to detailed instructions as well as the sample UB04 claim included in this manual for the correct format and reporting of covered/non-covered days.

FL 42 – 47 Line Item Reporting

Inpatient Line Item Reporting:

Submit your claim under Revenue code 0100 - All Inclusive Room, Board and Ancillaries, reporting total covered day units and total host state rate charges. 0001 summary total charges reported in FL 47, Line 23 should also reflect total host state rate charges, matching charges reported as the individual charge line.

Example - 10 day stay, all days approved:

Line Item Charges

Required - individual line items **(**Lines 1-22) allow up to nine numeric digits (0,000,000.00); 7 positions for dollars, 2 positions for cents.

Revenue Code	Units	Total Charges
0100	10	(total host state rate)

Total (Summary) Charges

Required - Line 23 of the final claim page using Revenue Code 0001.

Revenue Code	Units	Total Charges
0001		(total host state rate)

Outpatient Line Item Reporting:
Submit your claim under itemized revenue codes. Line item charges should reflect the host state rates or hospital total charges, whichever is the lesser amount. Summary total charge line should reflect the total of all itemized line items.

Example:

Line Item Charges
Required - individual line items (Lines 1-22) allow up to nine numeric digits (0,000,000.00); 7 positions for dollars, 2 positions for cents.

Revenue Code	Units	Total Charges
0250	1	(lesser of host state rate or hospital charges)
0300	1	(lesser of host state rate or hospital charges)

Total (Summary) Charges
Required - Line 23 of the final claim page using Revenue Code 0001.

Revenue Code	Units	Total Charges
0001		(total of line item charges)

FL 57 **Other (Billing) Provider Identifier - Legacy**

You must report your 9-digit Maryland Medicaid provider number in this field when submitting paper claims into the Program.

FL 60 **Insured's Unique ID**

The Maryland Medical Assistance recipient ID must be the last entry in this field as a payer of last resort.

FL 63 **Treatment Authorization Code**

The MDH 3808 document number must appear in this field on inpatient claims.

FL 66-67a-q **Diagnosis Codes and Procedure Codes**

The diagnosis and procedure codes must be ICD-9-CM. When submitting inpatient claims, diagnosis and procedure codes must match the coding as it appears on the MDH 3808.

FL 76 **Attending Physician / FL 77: Operating Physician**

You must report a 9-digit Maryland Medicaid ID in these fields. Refer to detailed instructions for more information.

ST\TE 0F \I,\RYLA1'D
DHMH
Office of Health Services
Medical Care Programs
Maryland Department of Health and Mental Hygiene
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HealthChoice and Acute Care Administration

Memorandum

TO: Hospital Providers

FROM: Stephanie Oliver, Chief SD
Division of Hospital and Professional Services

RE: New Process for submitting claims to Maryland Medicaid

Date: September 28, 2009

This memorandum is to notify all hospitals outside of the state of Maryland excluding the District of Columbia of two major changes in the claim payment process by the Maryland Medicaid Program, hereafter called the Program. One change deals with the accuracy of billed charges and the other adds a medical documentation review to validate the delivery and documentation of services.

Billed Charges

Based on federal regulations, the Program is mandated to reimburse hospitals outside of Maryland by the amount reimbursable by the host state's Title XIX agency. In order to do this, the Program has developed the following process.

For claims with dates of service on or after October 1, 2009, the Program will require out of state hospitals to submit claims that reflect their host state rate. The Program will reimburse claims from out of state hospitals at 100% of the charged amount. Specific billing instructions can be found at http://mdh.state.md.us/html/npi instructions.htm

In order for the Program to ensure that claims are being submitted and paid at the appropriate host state rate, the Program will use a contractor to verify all billed and paid amounts. The current contractor is Health Compliance Associates, LLC (HCA). If HCA identifies an overpayment, you will be notified of the amount of the overpayment and instructions for repayment.

Additionally, COMAR 10.09.36.0?(C) stipulates that providers will be responsible for reimbursing the Department any costs incurred in seeking the recovery of overpayments. The contingency fee for the validation of the hospital rates is percentage of the overpayment, which varies annually and will be charged to the hospitals. Providers are strongly encouraged to validate the accuracy of the billed amount prior to submitting any claim to the Program.

Medical Documentation Review

Since the 1980's, Maryland hospitals have been subject to medical documentation review of claims. The purpose of these reviews is to identify billing errors and recover inappropriately paid funds from inpatient and outpatient services. HCA will begin conducting post payment reviews of itemized bills to ensure that reimbursement is based on actual services rendered and documented beginning with dates of service October1, 2004. These overpayments will also be subject to a contingency fee that will be charged to the hospitals in addition to the overpayment.

Hospitals are strongly encouraged to validate the delivery and documentation of all services included on the claim prior to submission. For past dates of service, if you discover an overpayment through your own documentation review, please do the appropriate claims adjustments.

If you have additional questions, please contact Denise James, Hospital Program Supervisor at 410-767-1722.

UB04 Hospital

Revenue Code Matrix

UB04
REVENUE CODE
MATRIX

Units of service are required for every revenue code except 0001 - Total Charge.

Each revenue code may only be used once. The last revenue code on line 23 of the last page of the claim must be 0001 - Total Charge.

The table on the next page lists the only revenue codes recognized by the Maryland Medical Assistance Program. Use of any other codes will result in either rejection or return of the invoice or non-payment of the individual revenue code.

The table also indicates that some of the codes are not used (NU), or not payable (NP) or not covered (NC).

Finally, the table indicates the revenue codes which must be reported at a greater than zero level. Non - payable subheadings are identified - National non-assigned subheadings have not been included.

Medicaid Revenue Code Matrix Table

Revenue Code	Detail Greater Than Zero Level Required
001X	X
002X	NP
010X	
011X	X
012X	X
013X	X
014X	NP
015X	X
016X	
017X	X
018X	NU
019X	NU
020X	X
021X	
022X	X
023X	NP
024X	
025X	
026X	
027X	
028X	
029X	X
030X	
031X	
032X	
033X	NU
034X	
035X	
036X	
037X	
038X	
039X	

Revenue Code	Detail Greater Than Zero Level Required
054X	X
055X	NP
056X	NP
057X	NP
058X	NP
059X	NP
060X	NP
061X	
062X	
063X	
064X	NP
065X	
066X	NP
067X	NP
068X	NP
070X	
071X	
072X	
073X	
074X	
075X	
076X	
077X	NP
078X	
079X	
080X	X
081X	
082X	
083X	
084X	
085X	
088X	X

Medicaid Revenue Code Matrix Table

Revenue Code	Detail Greater Than Zero Level Required
040X	
041X	
042X	
043X	
044X	
045X	
046X	
047X	
048X	
049X	
050X	X
051X	
052X	NC
053X	

Revenue Code	Detail Greater Than Zero Level Required
090X	
091X	X
092X	X
093X	NC
094X	X
095X	NC
096X	X
097X	X
098X	X
099X	NP
100X	NC
210X	NC
310X	NC

NC = Not Covered NP = Not Payable NU – Not Used

0001 Total Charge

On the paper UB04 report the total for all revenue codes as indicated in FL47 Total Charges and FL48 Non-covered Charges on Line 23 of the last page of the UB04.
For electronic transactions, report the total charge in the appropriate data segment/field.

001X Reserved for Internal Payer Use

002X Health Insurance – Prospective Payment System (HIPPS) - NOT PAYABLE

This revenue code is used to denote that a HIPPS rate code is being reported in FL44.

	Subcategory	Standard Abbreviation
2	Skilled Nursing Facility – PPS **(Not Payable)**	SNF PPS (RUG)
3	Home Health – PPS **(Not Payable)**	HH PPS (HRG)
4	Inpatient Rehab Facility – PPS **(Not Payable)**	REHAB PPS (CMG)

003X to 009X RESERVED – NOT USED

010X All Inclusive Rate

Flat fee charge incurred on either a daily basis or total stay basis for services rendered. Charge may cover room and board plus ancillary services or room and board only.

Revenue codes 0100 and 0101 may not be used by Maryland general hospitals.

	Subcategory	Standard Abbreviation
0	All Inclusive Room and Board Plus Ancillary	ALL INCL R&B/ANC
1	All Inclusive Room and Board (Use this code if you bill ancillaries separately from room and board)	ALL INCL R&B
9	RESERVED-NOT COVERED	RESERVED – NOT COVERED

011X Room & Board – Private (One Bed)

Requires condition code 39 (Private Stay Medically Necessary), Justification Required on Form 3808. Routine service charges for single bedrooms.

Rational: Most third party payers require that private rooms be separately identified.

	Subcategory	Standard Abbreviation
1	Medical/Surgical/GYN	MED-SURG-GY/PVT
2	Obstetrics (OB)	OB/PVT
3	Pediatric	PEDS/PVT
4	Psychiatric	PSYCH/PVT
5	Hospice (Not Payable)	HOSPICE/PVT
6	Detoxification	DETOX/PVT
7	Oncology	ONCOLOGY/PVT
8	Rehabilitation	REHAB/PVT
9	Other (written description required)	OTHER/PVT

012X Room & Board - Semi-Private (Two Beds)

Routine service charges incurred for accommodations in a semi-private room (2 beds).

Rationale: Most third party payers require that semi-private rooms be identified.

	Subcategory	Standard Abbreviation
1	Medical/Surgical/GYN	MED-SURG-GY/SEMI
2	Obstetrics (OB)	OB/SEMI-PVT
3	Pediatric	PEDS/SEMI-PVT
4	Psychiatric	PSYCH/SEMI-PVT
5	Hospice (**Not Payable**)	HOSPICE/SEMI-PVT
6	Detoxification	DETOX/SEMI-PVT
7	Oncology	ONCOLOGY/SEMI-PVT
8	Rehabilitation	REHAB/SEMI-PVT
9	Other (written description required)	OTHER/SEMI-PVT

013X Room & Board - Three and Four Beds

Routine service charges for rooms containing three and four beds.

	Subcategory	Standard Abbreviation
1	Medical/Surgical/GYN	MED-SURG-GY/3&4 BED
2	Obstetrics (OB)	OB/3&4 BED
3	Pediatric	PEDS/3&4 BED
4	Psychiatric	PSYCH/3&4 BED
5	Hospice (**Not Payable**)	HOSPICE/3&4 BED
6	Detoxification	DETOX/3&4 BED
7	Oncology	ONCOLOGY/3&4 BED
8	Rehabilitation	REHAB/3&4 BED
9	Other (written description required)	OTHER/3&4 BED

014X Room & Board – Deluxe Private - NOT PAYABLE

Deluxe rooms are accommodations with amenities substantially in excess of those provided to other patients.

015X Room & Board - Ward

Routine service charge for accommodations with five or more beds.

Rationale: Most third-party payers require ward accommodations to be identified.

	Subcategory	Standard Abbreviation
1	Medical/Surgical/GYN	MED-SURG-GY/WARD
2	Obstetrics (OB)	OB/WARD
3	Pediatric	PEDS/WARD
4	Psychiatric	PSYCH/WARD
5	Hospice (**Not Payable**)	HOSPICE/WARD
6	Detoxification	DETOX/WARD
7	Oncology	ONCOLOGY/WARD
8	Rehabilitation	REHAB/WARD
9	Other (written description required)	OTHER/WARD

016X Room & Board - Other

Any routine service charges for accommodations that cannot be included in the more specific revenue center codes. Sterile environment is a room and board charge to be used by hospitals that are currently separating this charge for billing.

	Subcategory	Standard Abbreviation
0	General Classification **(Not payable)**	R&B
4	Sterile Environment **(Not payable)**	R&B/STERILE
7	Self Care **(Not payable)**	R&B/SELF
9	Other **–Administrative Days**	R&B/OTHER-ADMIN DAYS

017X Nursery

Charges for nursing care to newborn and premature infants in nurseries.

Rationale: Provides a breakdown of various levels of nursery care. Tertiary care is a level of care between premature and regular nursery care.

	Subcategory	Standard Abbreviation
1	Newborn – Level I (Newborn Nursery)	NURSERY/LEVEL I
2	Newborn – Level II (Continuing Care)	NURSERY/LEVEL II
3	Newborn – Level III (Intermediate Care)	NURSERY/LEVEL III
4	Newborn – Level IV (Intensive Care)	NURSERY/LEVEL IV
9	Other Nursery	NURSERY - OTHER

Note: The levels of care correlate to the intensity of medical care provided to an infant and NOT
the NICU facility certification level assigned by the state.

Level I: Routine care of apparently normal full-term or pre-term neonates (Newborn Nursery).
Level II: Low birth-weight neonates who are not sick, but require frequent feeding, and neonates who require more hours of nursing than do normal neonates. (Continuing Care).
Level III: Sick neonates, who do not require intensive care, but require 6-12 hours of nursing each day. (Intermediate Care)
Level IV: Constant nursing and continuous cardiopulmonary and other support for severely ill infants. (Intensive Care)

018X **Leave of Absence - NOT PAYABLE UNDER HOSPITAL PROGRAM**

Charges for holding a room while the patient is temporarily away from the provider.

	Subcategory	Standard Abbreviation
10	General Classification	Leave of Absence or LOA
2	Patient Convenience	LOA/PT CONV
3	Therapeutic Leave	LOA/THERAPEUTIC
5	Nursing Home (for Hospitalization)	LOA/NURS HOME
9	Other LOA (Written documentation required)	LOA/OTHER

019X **Subacute Care – NOT PAYABLE UNDER HOSPITAL PROGRAM**

Accommodation charges for subacute care to inpatients or skilled nursing facilities.

	Subcategory	Standard Abbreviation
10	General Classification	SUBACUTE
1	Subacute Care – Level I	SUBACUTE – LEVEL I
2	Subacute Care – Level II	SUBACUTE – LEVEL II
3	Subacute Care – Level III	SUBACUTE – LEVEL III
4	Subacute Care – Level IV	SUBACUTE – LEVEL IV
9	Other Subacute Care (Written documentation required)	SUBACUTE /OTHER

020X **Intensive Care Unit**

Routine service charge for medical or surgical care provided to patients who require a more intensive level of care than is rendered in the general medical or surgical unit.

Rationale: Most third-party payers require that charges for this service are to be identified.

	Subcategory	Standard Abbreviation
1	Surgical	ICU/SURGICAL
2	Medical	ICU/MEDICAL
3	Pediatric	ICU/PEDS
4	Psychiatric	ICU/PSYCH
6	Intermediate ICU	ICU/INTERMEDIATE
7	Burn Care	ICU/BURN CARE
8	Trauma	ICU/TRAUMA
9	Other Intensive Care (written documentation required)	ICU/OTHER

021X Coronary Care Unit

Routine service charge for medical care provided to patients with coronary illness who require a more intensive level of care than is rendered in the general medical care unit.

Note: If a discrete coronary care unit exists for rendering such services, the hospital or third party may wish to identify the service.

	Subcategory	Standard Abbreviation
10	General Classification	CORONARY CARE
1	Myocardial Infarction	CCU/MYO INFARC
2	Pulmonary Care	CCU/PULMONARY
3	Heart Transplant	CCU/TRANSPLANT
4	Intermediate-CCU	CCU/INTERMEDIATE
9	Other Coronary Care (written description required)	CCU/OTHER

022X Special Charges

Charges incurred during an inpatient stay or on a daily basis for certain services.

	Subcategory	Standard Abbreviation
1	Admission Charge	ADMIT CHARGE

023X Incremental Nursing Charge - NOT PAYABLE UNDER HOSPITAL PROGRAM

Extraordinary charges for nursing services assessed in addition to the normal nursing charge associated with the typical room and board unit.

024X All Inclusive Ancillary - NOT TO BE USED BY MARYLAND HOSPITALS

A flat rate charge incurred on either a daily basis or total stay basis for ancillary services only when authorized by the host states Medicaid Agency.

Rationale: Hospitals that bill in this manner may wish to segregate these charges.

	Subcategory	Standard Abbreviation
10	General Classification	ALL INCL ANCIL
9	Other Inclusive Ancillary (written description required)	ALL INCL/ANCIL/OTHER

025X **Pharmacy (**Must report NDC code on outpatient claims for dates of service 7/1/2008 forward**)**

Charges for medication produced, manufactured, packaged, controlled, assayed, dispensed and distributed under the direction of licensed pharmacist.

	Subcategory	Standard Abbreviation
10	General Classification	PHARMACY
1	Generic Drugs	DRUGS/GENERIC
2	Non-Generic Drugs	DRUGS/NONGENERIC
3	Take Home Drugs **(Not covered)**	DRUGS/TAKEHOME
4	Drugs Incident to Other Diagnostic Services **(Not covered)**	DRUGS/INCIDENT OTHER DX
5	Drugs Incident to Radiology **(Not covered)**	DRUGS/INCIDENT RAD
6	Experimental Drugs **(Not covered)**	DRUGS/EXPERIMT
7	Non-Prescription Drugs	DRUGS/NONPSCRPT
8	IV Solutions	IV SOLUTIONS
9	Other Pharmacy (written description required)	DRUGS/OTHER

026X **IV Therapy**

Code indicates the equipment charge or administration of intravenous solution by specially trained personnel to individuals requiring such treatment.

	Subcategory	Standard Abbreviation
10	General Classification	IV THERAPY
1	Infusion Pump	IV THER/INFSN PUMP
2	IV Therapy/Pharmacy Svcs (**Not payable**)	IV THER/PHARM SVC
3	IV Therapy/Drug/Supply Delivery (**Not payable**)	IV THER/DRGU/SUPPLY/DEL
4	IV Therapy/Supplies (**Not payable**)	IV THER/SUPPLIES
9	Other IV Therapy (written description required)	IV THERAPY/OTHER

027X **Medical/Surgical Supplies and Devices (Also see 062X, an extension of 027X)**

Charges for supply items required for patient care.

	Subcategory	Standard Abbreviation
10	General Classification	MED-SUR SUPPLIES
1	Non Sterile Supply	NON-STER SUPPLY
2	Sterile Supply	STERILE SUPPLY
3	Take Home Supplies **(Not payable)**	TAKEHOME SUPPLY
4	Prosthetic/Orthotic Devices	PROSTH/ORTH DEV
5	Pace Maker	PACE MAKER
6	Intraocular Lens	INTRA OC LENS
7	Oxygen - Take Home **(Not payable)**	O2/TAKEHOME
8	Other Implants [(a)]	SUPPLY/IMPLANTS
9	Other Supplies/Devices (written description required)	SUPPLY/OTHER

(a) Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, or a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. An object or material partially or totally inserted or grafted into the body for prosthetic, therapeutic, diagnostic purposes.

Examples of other implants (not all-inclusive): Stents, artificial joints, shunts, grafts, pins, plates, screws, anchors, radioactive seeds.

Experimental devices that are implantable and have been granted an FDA Investigational Device Exemption (IDE) number should be billed with revenue code 0624.

028X Oncology

Charges for the treatment of tumors and related diseases.

	Subcategory	Standard Abbreviation
10	General Classification	ONCOLOGY
9	Other Oncology (written description required)	ONCOLOGY/OTHER

029X Durable Medical Equipment (Other Than Renal)

Charges for medical equipment that can withstand repeated use (excluding renal equipment).

	Subcategory	Standard Abbreviation
1	Rental	DME-RENTAL
2	Purchase of new DME	DME-NEW
3	Purchase of used DME	DME-USED
4	Supplies/Drugs for DME (**Not payable**)	DME-SUPPLIES/DRUGS
9	Other Equipment (written description required)	DME-OTHER

030X Laboratory

Charges for the performance of diagnostic and routine clinical laboratory tests.

	Subcategory	Standard Abbreviation
0	General Classification	MED-SUR SUPPLIES
1	Chemistry	CHEMISTRY TESTS
2	Immunology	IMMUNOLOGY TESTS
3	Renal Patient (Home)	RENAL-HOME
4	Non-Routine Dialysis	NON-RTNE DIALYSIS
5	Hematology	HEMATOLOGY TESTS
6	Bacteriology & Microbiology	BACT & MICRO TESTS
7	Urology	UROLOGY TESTS
9	Other Laboratory (written description required)	OTHER LAB TESTS

031X Laboratory Pathology

Charges for diagnostic and routine laboratory tests on tissues and culture.

	Subcategory	Standard Abbreviation
10	General Classification	PATHOLOGY LAB
1	Cytology	CYTOLOGY TESTS
2	Histology	HISTOLOGY TESTS
4	Biopsy	BIOPSY TESTS
9	Other Laboratory Pathology (written description required)	PATH LAB OTHER

032X Radiology – Diagnostic

Charges for diagnostic radiology services including interpretation of radiographs and fluorographs.

	Subcategory	Standard Abbreviation
10	General Classification	DX X-RAY
1	Angiocardiology	DX X-RAY/ANGIO
2	Arthrography	DX X-RAY/ARTHO
3	Arteriography	DX X-RAY/ARTER
4	Chest X-Ray	DX X-RAY/CHEST
9	Other Radiology –Diagnostic (written description required)	DX X-RAY/OTHER

033X Radiology – Therapeutic and/or Chemotherapy Administration

Charges for therapeutic radiology services and chemotherapy administration to care and treat patients. Therapies also include injection and/or ingestion of radioactive substances. Excludes charges for chemotherapy drugs; report these under the appropriate revenue code (025x). Usage note: When using 0331, 0332, or 0335 there must be use of Revenue Code 025x.

	Subcategory	Standard Abbreviation
10	General Classification (**Not payable**)	RADIOLOGY THERAPY
1	Chemotherapy Admin – Injected	RAD-CHEMO-INJECT
2	Chemotherapy Admin – Oral	RAD-CHEMO-ORAL
3	Radiation Therapy	RAD-RADIATION
5	Chemotherapy Admin – IV	RAD-CHEMO-IV
9	Other Radiology –Therapeutic (written description required)	RADIOLOGY OTHER

034X Nuclear Medicine

Charges for procedures, tests, and radiopharmaceuticals performed by a department handling radioactive materials as required for diagnosis and treatment of patients.

	Subcategory	Standard Abbreviation
10	General Classification	NUCLEAR MEDICINE
1	Diagnostic	NUC MED/DX
2	Therapeutic	NUC MED/RX
3	Diagnostic Radiopharmaceuticals	NUC MED/DX RADIOPHARM
4	Therapeutic Radiopharmaceuticals	NUC MED/RX RADIOPHARM
9	Other Nuclear Medicine (written description required)	NUC MED/OTHER

035X CT Scan

Charges for computed tomographic scans of the head and other parts of the body.

	Subcategory	Standard Abbreviation
0	General Classification	CT SCAN
1	CT Head Scan	CT SCAN/HEAD
2	CT Body Scan	CT SCAN/BODY
9	CT Other (written description required)	CT SCAN/OTHER

036X Operating Room Services

Charges for services provided to patients by specifically trained nursing personnel who provide assistance to physicians in the performance of surgical and related procedures during and immediately following surgery.

	Subcategory	Standard Abbreviation
10	General Classification	OR SERVICES
1	Minor Surgery	OR/MINOR
2	Organ Transplant - Other Than Kidney	OR/ORGAN TRANS
7	Kidney Transplant	OR/KIDNEY TRANS
9	Other OR Services (written description required)	OR/OTHER

037X Anesthesia

Charges for anesthesia services.

	Subcategory	Standard Abbreviation
10	General Classification	ANESTHESIA
1	Anesthesia Incident to Radiology	ANESTH/INCIDENT RAD
2	Anesthesia Incident to Other Diagnostic Services	ANESTH/INCIDNT OTHR DX
4	Acupuncture **(Not Payable)**	ANESTHE/ACUPUNC
9	Other Anesthesia (written description required)	ANESTHE/OTHER

038X Blood and Blood Components

Charges for blood and blood components.

	Subcategory	Standard Abbreviation
10	General Classification	BLOOD & BLOOD COMP
1	Packed Red Cells	BLOOD/PKD RED
2	Whole Blood	BLOOD/WHOLE
3	Plasma	BLOOD/PLASMA
4	Platelets	BLOOD/PLATELETS
5	Leukocytes	BLOOD/LEUKOCYTES
6	Other Blood Components	BLOOD/COMPONENTS
7	Other Derivatives (Cryoprecipitate)	BLOOD/DERIVATIVES
9	Other Blood and Blood Components (written description required)	BLOOD/OTHER

039X Administration, Processing, and Storage for Blood and Blood Components

Charges for administration, processing and storage of whole blood, red blood cells, platelets, and other blood components.

	Subcategory	Standard Abbreviation
10	General Classification Administration (e.g., Transfusion)	BLOOD/ADMIN/STOR
1	Administration (e.g., Transfusion)	BLOOD/ADMIN
2	Processing and Storage	BLOOD/STORAGE
9	Other Blood Handling (written description required)	BLOOD/ADMIN/STOR/OTHER

040X Other Imaging Services

Charges for specialty imaging services for body structures.

	Subcategory	Standard Abbreviation
10	General Classification	IMAGING SERVICE
1	Diagnostic Mammography	DIAG MAMMOGRAPHY
2	Ultrasound	ULTRASOUND
3	Screening Mammography	SCRN MAMMOGRAPHY
4	Positron Emission Tomography	PET SCAN
9	Other Imaging Services (written description required)	OTHER IMAGE SVS

041X Respiratory Services

Charges for respiratory services including administration of oxygen and certain potent drugs through inhalation or positive pressure and other forms of rehabilitative therapy.

	Subcategory	Standard Abbreviation
10	General Classification	RESPIRATORY SVC
2	Inhalation Services	INHALATION SVC
3	Hyperbaric Oxygen Therapy	HYPERBARIC 02
9	Other Respiratory Services (written description required)	OTHER RESPIR SVS

042X Physical Therapy

Charges for therapeutic exercises, massage and utilization of Effective Date properties of light, heat, cold, water, electricity, and assistive devices for diagnosis and rehabilitation of patients who have neuromuscular, orthopedic and other disabilities.

	Subcategory	Standard Abbreviation
10	General Classification	PHYSICAL THERAP
1	Visit	PHYS THERP/VISIT
2	Hourly	PHYS THERP/HOUR
3	Group	PHYS THERP/GROUP
4	Evaluation or Re-Evaluation	PHYS THERP/EVAL
9	Other Physical Therapy (written description required)	OTHER PHYS THER

043X Occupational Therapy

Charges for therapeutic interventions to improve, sustain, or restore an individual's level of function in performance of activities of daily living and work, including: therapeutic activities, therapeutic exercises, sensorimotor processing, psychosocial skills training, cognitive retraining, fabrication and application of orthotic devices, training in the use of orthotic and prosthetic devices, adaptation of environments, and application of psychical agent modalities.

Services are provided by a qualified occupational therapist.

	Subcategory	Standard Abbreviation
10	General Classification	OCCUPATIONAL THER
1	Visit	OCCUP THERP/VISIT
2	Hourly	OCCUP THERP/HOUR
3	Group	OCCUP THER/GROUP
4	Evaluation or Re-Evaluation	OCCUP THER/EVAL
9	Other Occupational Therapy (written description required)	OCCUP THER/OTHER

044X Speech Therapy - Language Pathology

Charges for services provided to persons with impaired functional communications skills.

	Subcategory	Standard Abbreviation
10	General Classification	SPEECH THERAPY
1	Visit	SPEECH THERP/VISIT
2	Hourly	SPEECH THERP/HOUR
3	Group	SPEECH THERP/GROUP
4	Evaluation or Re-Evaluation	SPEECH THERP/EVAL
9	Other Speech Therapy (written description required)	SPEECH THERP/OTHER

045X Emergency Room

Charges for emergency treatment to those ill and injured persons who require immediate unscheduled medical or surgical care.

	Subcategory	Standard Abbreviation
10	General Classification	EMERG ROOM
1	EMTALA Emergency Medical Screening *(outpatient claims only)*	ER/EMTALA
2	ER Beyond EMTALA Screening *(outpatient claims only)*	ER/BEYOND EMTALA
6	Urgent Care *(outpatient claims only)*	ER/URGENT
9	Other Emergency Room *(outpatient claims only)* (written description required)	OTHER EMERGENCY ROOM

Usage Notes:
Report Patient's Reason for Visit Code (FL70) in conjunction with this revenue code.

The list below indicates the acceptable coding:
(a) General classification code 0450 should not be used in conjunction with any subcategory. The sum of 0451 and 0452 is the equivalent to 0450.
(b) Stand-alone usage of 0451 is acceptable when no services beyond an initial screening/assessment are rendered.
(c) Stand-alone usage of 0452 is not acceptable.

046X Pulmonary Function

Charges for tests that measure inhaled and exhaled gases, analyze blood, and evaluate the patient's ability to exchange oxygen and other gases.

	Subcategory	Standard Abbreviation
10	General Classification	PULMONARY FUNC
9	Other Pulmonary Function (written description required)	OTHER PULMONARY FUNC

047X Audiology

Charges for the detection and management of communication handicaps centering, in whole or in part, on the hearing function.

	Subcategory	Standard Abbreviation
10	General Classification	AUDIOLOGY
1	Diagnostic	AUDIOLOGY/DX
2	Treatment	AUDIOLOGY/RX
9	Other Audiology (written description required)	OTHER AUDIOL

The below HCPCS are required when billing for a cochlear implant or BAHA surgery (see Hospital Transmittal No. 260 dated July 12, 2018).

Procedure Code	Description	Maximum Fee
L8614	Cochlear device, includes all internal and external components	$18,853.31
L8690	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment	$4,515.27

048X Cardiology

Charges for cardiac procedures rendered by staff from the cardiology department of the hospital or under arrangement. Such procedures include, but are not limited to: heart catheterization, coronary angiography, Swan-Ganz catheterization, and exercise stress test.

	Subcategory	Standard Abbreviation
10	General Classification	CARDIOLOGY
1	Cardiac Cath Lab	CARDIAC CATH LAB
2	Stress Test	STRESS TEST
3	Echocardiology	ECHOCARDIOLOGY
9	Other Cardiology (written description required)	OTHER CARDIOLOGY

049X Ambulatory Surgical Care

Charges for ambulatory surgery not covered by other categories.

	Subcategory	Standard Abbreviation
10	General Classification	AMBULTRY SURG
9	Other Ambulatory Surgical (written description required)	OTHER AMBUL SURG

050X Outpatient Services (To be used on inpatient bill only)

Charges for services rendered to an outpatient who is admitted as an inpatient before midnight of the day following the date of service. These charges are incorporated on the inpatient bill. (Note: Medicare no longer requires this revenue code).

	Subcategory	Standard Abbreviation
9	Other Outpatient (written description required)	OTHER – O/P SERVICES

051X Clinic

Clinic (non-emergency/scheduled outpatient visit) charges for providing diagnostic, preventive, curative, rehabilitative, and education services on a scheduled basis to ambulatory patients.

	Subcategory	Standard Abbreviation
0	General Classification	CLINIC
1	Chronic Pain Center	CHRONIC PAIN CLINIC
2	Dental Clinic **(Not Payable)**	DENTAL CLINIC
3	Psychiatric Clinic	PSYCHIATRIC CLINIC
4	OB-GYN Clinic	OB-GYN CLINIC
5	Pediatric Clinic	PEDIATRIC CLINC
6	Urgent Care Clinic* **(Not Payable)**	URGENT CARE CLINIC
7	Family Practice Clinic **(Not Payable)**	FAMILY CLINIC
9	Other Clinic (written description required)	OTHER CLINC

*Report the Patient's Reason for Visit diagnosis codes for all Urgent Care Clinic visits.

052X Free-Standing Clinic - NOT COVERED

053X Osteopathic Services - Hospital Charges

Charges for a structural evaluation of the cranium, entire cervical, dorsal and lumber spine by a doctor of osteopathy.

Rationale: Generally, these services are unique to osteopathic hospitals and cannot be accommodated in any of the existing codes. The use of this revenue code is restricted to a hospital charging for osteopathic services.

	Subcategory	Standard Abbreviation
10	General Classification	OSTEOPATH SVS
1	Osteopathic Therapy	OSTEOPATH RX
9	Other Osteopathic Services (written description required)	OTHER OSTEOPATH

054X Ambulance

Charges for ambulance services necessary for the transport of the ill or injured who require medical attention at a health care facility.

	Subcategory	Standard Abbreviation
10	General Classification **(Not Payable)**	AMBULANCE
1	Supplies **(Not Payable)**	AMBUL/SUPPLY
2	Medical Transport	AMBUL/MED TRANS
3	Heart Mobile **(Not Payable)**	AMBUL/HEART MOB
4	Oxygen **(Not Payable)**	AMBUL/OXYGEN
5	Air Ambulance **(Not Payable)**	AIR AMBULANCE
6	Neonatal Ambulance Services **(Not Payable)**	AMBUL/NEONAT
7	Pharmacy **(Not Payable)**	AMBUL/PHARMAS
8	EKG Transmission	AMBUL/EKG TRANS
9	Other Ambulance (written description required)	OTHER AMBULANCE

055X Skilled Nursing - NOT PAYABLE UNDER THE HOSPITAL PROGRAM

Charges for nursing services that must be provided under the direct supervision of a licensed nurse to assure the safety of the patient and to achieve the medically desired result. This code may be used for nursing home services, CORFS, or a service charge for home health billing.

056X Home Health (HH) - Medical Social Services - NOT PAYABLE UNDER THE HOSPITAL PROGRAM

Home Health (HH) charges for services such as counseling patients, interviewing patients, and interpreting problems of social situation rendered to patients on any basis.

057X Home Health (HH) Aide - NOT PAYABLE UNDER THE HOSPITAL PROGRAM

Home Health (HH) charges for personnel (aides) that are primarily responsible for the personal care of the patient.

058X Home Health (HH) - Other Visits - NOT PAYABLE UNDER THE HOSPITAL PROGRAM

Home Health (HH) agency charges for visits other than physical therapy, occupational therapy or speech therapy, requiring specific identification.

059X **Home Health (HH) - Units of Service - NOT PAYABLE UNDER THE HOSPITAL PROGRAM**

Home Health (HH) charges for services billed according to the units of service provided.

060X **Home Health (HH) - Oxygen - NOT PAYABLE UNDER THE HOSPITAL PROGRAM**

061X **Magnetic Resonance Technology (MRT)**

Charges for Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA).

	Subcategory	Standard Abbreviation
0	General Classification	MRT
1	MRI - Brain/Brainstem	MRI/BRAIN
2	MRI - Spinal Cord/Spine	MRI/SPINE
4	MRI-OTHER **(Not payable)**	MRI/OTHER
5	MRA – Head and Neck **(Not payable)**	MRA/HEAD & NECK
6	MRA – Lower Extremities **(Not payable)**	MRA/LOWER EXTRM
8	MRA – OTHER **(Not payable)**	MRA/OTHER
9	Other MRT (**Not payable**)	MRT/OTHER

062X **Medical/Surgical Supplies - Extension of 27X**

Charges for supply items required for patient care. The category is an extension of 027X for reporting additional breakdown where needed. Subcategory code 1 is for providers that cannot bill supplies used for radiology procedures under radiology. Subcategory code 2 is for providers that cannot bill supplies used for other diagnostic procedures.

	Subcategory	Standard Abbreviation
1	Supplies Incident to Radiology	MED-SUR SUPL - INCDT RAD
2	Supplies Incident to Other DX Services	MED-SUR SUPL - INCDT ODX

063X **Drugs Requiring Specific Identification**

	Subcategory	Standard Abbreviation
6	Drugs Requiring Detailed Coding (a)	DRUG/DETAIL CODE
7	Self-Administrable Drugs (b)	DRUG/SELF ADMIN

(a) Charges for drugs and biologics (with the exception of radiopharmaceuticals reported under Revenue Codes 0343 and 0344) requiring specific identification. (Must report NDC code on outpatient claims for dates of service 12/1/2014 forward).

(b) Charges for self-administrable drugs not requiring detailed coding. Use Value Codes A4, A5, and A6 to indicate the dollar amount included in covered charges for self-administrable drugs. Amounts for non-covered self-administrable drugs should be charged using Revenue Code 0637 in the non-covered column. **(**Must report NDC Code on outpatient claims for dates of service 7/1/2008 forward**).**

064X **Home IV Therapy Services - NOT PAYABLE**

065X **Hospice Service – NOT PAYABLE UNDER HOSPITAL PROGRAM**

066X **Respite Care - NOT PAYABLE UNDER HOSPITAL PROGRAM**

067X **Outpatient Special Residence Charges – NOT PAYABLE**

Residence arrangements for patients requiring continuous outpatient care.

068X **Trauma Response NOT PAYABLE**

Charges representing the activation of the trauma team.

069X **Reserved/Not Assigned**

070X **Cast Room**

Charges for services related to the application, maintenance and removal of casts.

	Subcategory	Standard Abbreviation
0	General Classification	CAST ROOM
1-9	RESERVED	

071X **Recovery Room**

Room charge for patient recovery after surgery.

	Subcategory	Standard Abbreviation
0	General Classification	RECOVERY ROOM
1-9	RESERVED	

072X **Labor Room/Delivery**

	Subcategory	Standard Abbreviation
10	General Classification	DELIVERY ROOM/LABOR
1	Labor	LABOR
2	Delivery Room	DELIVERY ROOM
3	Circumcision	CIRCUMCISION
4	Birthing Center	BIRTHING CNTR
9	Other Labor Room/Delivery (written description required)	OTHER/DELIV-LABOR

073X **EKG/ECG (Electrocardiogram)**

Charges for operation of specialized equipment to record variations in action of the heart muscle for diagnosis of heart ailments.

	Subcategory	Standard Abbreviation
10	General Classification	EKG/ECG
1	Holter Monitor	HOLTER MONT
2	Telemetry (includes fetal monitoring)	TELEMETRY
9	Other EKG/ECG (written description required)	OTHER EKG/ECG

074X EEG (Electroencephalogram)

Charges for operation of specialized equipment to measure impulse frequencies and differences in electrical potential in various areas of the brain to obtain data for use in diagnosing brain disorders.

	Subcategory	Standard Abbreviation
0	General Classification	EEG
1-9	RESERVED	

075X Gastro Intestinal Services (GI) Services

Charges for GI procedures not performed in the operating room.

	Subcategory	Standard Abbreviation
0	General Classification	GASTR-INST SVS
1-9	RESERVED	

076X Specialty Room - Treatment/Observation Room

Charges for the use of specialty rooms such as treatment or observation rooms.

	Subcategory	Standard Abbreviation
10	General Classification	SPECIALTY ROOM
1	Treatment Room	TREATMENT RM
2	Observation Room [(a)]	OBSERVATION RM
9	Other Specialty Rooms (written description required)	OTHER SPECIALTY RMS

(a) FL 76 – Patient's Reason for Visit should be reported in conjunction with 0762.

077X Preventive Care Services – NOT PAYABLE

Revenue Code used to capture preventive care services established by payers (e.g., vaccination).

	Subcategory	Standard Abbreviation
0	General Classification **(Not payable)**	PREVENT CARE SVCS
1	Vaccine Administration **(Not payable)**	VACCINE ADMIN

078X Telemedicine

Facility charges related to the use of telemedicine services. **This revenue code is payable for dates of service 10/1/13 forward.**

	Subcategory	Standard Abbreviation
0	General Classification	TELEMEDICINE

079X Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy)

Charges related to Extra-Corporeal Shock Wave Therapy (ESWT).

	Subcategory	Standard Abbreviation
0	General Classification	ESWT
1-9	RESERVED	

080X Inpatient Renal Dialysis

Charges for the use of equipment that is designed to remove waste when the body's own kidneys have failed. The waste may be removed directly from the blood (hemodialysis) or indirectly from the blood by flushing a special solution between the abdominal covering and the tissue (peritoneal dialysis).

	Subcategory	Standard Abbreviation
1	Inpatient Hemodialysis	DIALY/INPATIENT
2	Inpatient Peritoneal (Non-CAPD)	DIALY/IP/PER
3	Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	DIALY/IP/CAPD
4	Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	DIALY/IP/CCPD
9	Other Inpatient Dialysis (written description required)	DIALY/IP/OTHER

081X Acquisition of Body Components

The acquisition and storage costs of body, tissue, bone marrow, organs and other body components not otherwise identified used for transplantation.

	Subcategory	Standard Abbreviation
10	General Classification	ORGAN ACQUISIT
1	Living Donor	LIVING DONOR
2	Cadaver Donor	CADAVER DONOR
3	Unknown Donor	UNKNOWN DONOR
4	Unsuccessful Organ Search – Donor Bank Charges	UNSUCCESSFUL SEARCH
9	Other Donor (written description required)	OTHER DONOR

Notes:
Unknown is used whenever the status of the individual source cannot be determined. Use the other category whenever the organ is non-human.

Revenue Code 0814 is used only when costs incurred for an organ search do not result in an eventual organ acquisition and transplantation.

082X **Hemodialysis - Outpatient or Home - PAYABLE ON OUTPATIENT CLAIMS FOR DATES OF SERVICE ON OR AFTER 7/1/2013**

A waste removal process, performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed directly from the blood.

	Subcategory	Standard Abbreviation
0	General Classification	HEMO/OP OR HOME
1	Hemodialysis Composite or Other Rate	HEMO/COMPOSITE
2	Home Supplies **(Not payable)**	HEMO/HOME/SUPPL
3	Home Equipment **(Not payable)**	HEMO/HOME/EQUIP
4	Maintenance - 100% **(Not payable)**	HEMO/HOME/100%
5	Support Services **(Not payable)**	HEMO/HOME/SUPSERV
6-8	RESERVED	
9	Other OP Hemodialysis **(Not payable)**	HEMO – OTHER OP

Note:
Maryland Medicaid will pay for renal dialysis in the emergency room if it is an emergency. Emergency in this context means that the patient cannot be safely sent back to the community provider for the dialysis. Medicaid will be closely monitoring claims for such services to ensure that hospitals are not routinely providing dialysis in lieu of free-standing dialysis facilities.

083X **Peritoneal Dialysis - Outpatient or Home - PAYABLE ON OUTPATIENT CLAIMS FOR DATES OF SERVICE ON OR AFTER 7/1/2013**

Charges for a waste removal process performed in an outpatient or home setting, necessary when the body's own kidneys have failed. Waste is removed by flushing a special solution between the abdominal covering and the tissue.

	Subcategory	Standard Abbreviation
10	General Classification	PERITONEAL/OP OR HOME
1	Peritoneal Composite or Other Rate	PERTNL/COMPOSITE
2	Home Supplies **(Not payable)**	PERTNL/HOME/SUPPL
3	Home Equipment **(Not payable)**	PERTNL/HOME/EQUIP
4	Maintenance - 100% **(Not payable)**	PERTNL/HOME/100%
5	Support Services **(Not payable)**	PERTNL/HOME/SUPSERV
6-8	RESERVED	
9	Other Outpatient Peritoneal Dialysis **(Not payable)**	PERTNL/HOME/OTHER

Note:
Maryland Medicaid will pay for renal dialysis in the emergency room if it is an emergency. Emergency in this context means that the patient cannot be safely sent back to the community provider for the dialysis. Medicaid will be closely monitoring claims for such services to ensure that hospitals are not routinely providing dialysis in lieu of free-standing dialysis facilities

084X **Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home - PAYABLE ON OUTPATIENT CLAIMS FOR DATES OF SERVICE ON OR AFTER 7/1/2013**

Charges for continuous dialysis performed in an outpatient or home setting which uses the patient peritoneal membrane as a dialyzer.

	Subcategory	Standard Abbreviation
0	General Classification	CAPD/OP OR HOME
1	CAPD Composite or Other Rate	CAPD /COMPOSITE
2	Home Supplies **(Not payable)**	CAPD /HOME/SUPPL
3	Home Equipment **(Not payable)**	CAPD/HOME/EQUIP
4	Maintenance - 100% **(Not payable)**	CAPD /HOME/100%
5	Support Services **(Not payable)**	CAPD /HOME/SUPSERV
6-8	RESERVED	
9	Other Outpatient CAPD **(Not payable)**	CAPD /HOME/OTHER

Note:
Maryland Medicaid will pay for renal dialysis in the emergency room if it is an emergency. Emergency in this context means that the patient cannot be safely sent back to the community provider for the dialysis. Medicaid will be closely monitoring claims for such services to ensure that hospitals are not routinely providing dialysis in lieu of free-standing dialysis facilities.

085X **Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home - PAYABLE ON OUTPATIENT CLAIMS FOR DATES OF SERVICE ON OR AFTER 7/1/2013**

Charges for continuous dialysis process performed in an outpatient or home setting which uses a machine to make automatic exchanges at night.

	Subcategory	Standard Abbreviation
0	General Classification	CCPD/OP OR HOME
1	CCPD Composite or Other Rate	CCPD /COMPOSITE
2	Home Supplies **(Not payable)**	CCPD /HOME/SUPPL
3	Home Equipment **(Not payable)**	CCPD/HOME/EQUIP
4	Maintenance - 100% **(Not payable)**	CCPD /HOME/100%
5	Support Services **(Not payable)**	CCPD /HOME/SUPSERV
6-8	RESERVED	
9	Other Outpatient CCPD **(Not payable)**	CCPD /HOME/OTHER

Note:
Maryland Medicaid will pay for renal dialysis in the emergency room if it is an emergency. Emergency in this context means that the patient cannot be safely sent back to the community provider for the dialysis. Medicaid will be closely monitoring claims for such services to ensure that hospitals are not routinely providing dialysis in lieu of free-standing dialysis facilities.

086X Reserved

087X Reserved

088X Miscellaneous Dialysis

Charges for dialysis services not identified elsewhere.

	Subcategory	Standard Abbreviation
1	Ultrafiltration	DIALY/ULTRAFILT
2	Home Dialysis Aid Visit **(Not payable)**	HOME DIALYSIS AID VISIT
9	Other Miscellaneous Dialysis (written description required)	DIALY/MISC/OTHER

Note:
Ultrafiltration is the process of removing excess fluid from the blood of dialysis patients by using a dialysis machine but without the dialysate solution. The designation is only used when the procedure is not performed as part of a normal dialysis session

089X Reserved

090X Behavioral Health Treatment/Services (also see 091x, an extension of 090x)

Charges for prevention, intervention, and treatment services in the areas of: mental health, substance abuse, developmental disabilities, and sexuality. Behavioral Health Care services are individualized, holistic, and culturally competent and may include on-going care and support and non-traditional services.

	Subcategory	Standard Abbreviation
10	General Classification	BH/TREATMENTS
1	Electroshock Treatment	BH/ELECTRO SHOCK
2	Milieu Therapy	BH/MILIEU THERAPY
3	Play Therapy	BH/PLAY THERAPY
4	Activity Therapy	BH/ACTIVITY THERAPY
5	Intensive Outpatient Services – Psychiatric	BH/INTENS OP/PSYCH
6	Intensive Outpatient Services – Chemical Dependency	BH/INTENS OP/CHEM DEP
7	Community Behavioral Health Program (Day Treatment)	BH/COMMUNITY

091X Behavioral Health Treatment/Services (an extension of 090x)

	Subcategory	Standard Abbreviation
0	RESERVED (use 090 for General Classification) **(Not payable)**	

	Subcategory	Standard Abbreviation
1	Rehabilitation	BH/REHAB
2	Partial Hospitalization – Less Intensive	BH/PARTIAL HOSP
3	Partial Hospitalization – Intensive	BH/PARTIAL INTENSV
4	Individual Therapy	BH/INDIV RX
5	Group Therapy	BH/GROUP RX
6	Family Therapy	BH/FAMILY RX
7	Bio Feedback	BH/BIOFEED
8	Testing	BH/TESTING
9	Other Behavioral Health Treatments (written description required)	BH/OTHER

092X Other Diagnostic Services

Charges for various diagnostic services specific to: common screenings for disease, illness, or medical condition.

	Subcategory	Standard Abbreviation
10	General Classification **(Not payable)**	OTHER DX SVCS
1	Peripheral Vascular Lab	PERI VASCUL LAB
2	Electromyogram	EMG
3	Pap Smear	PAP SMEAR
4	Allergy Test	ALLERGY TEST
5	Pregnancy Test	PREG TEST
9	Other Behavioral Health Treatments (written description required)	BH/OTHER

093X Medical Rehabilitation Day Program - NOT COVERED

Medical rehabilitation services as contracted with a payer and/or certified by the state. Services may include physical therapy, occupational therapy, and speech therapy.

	Subcategory	Standard Abbreviation
1	Half Day (**Not covered**)	HALF DAY
2	Full Day (**Not covered)**	FULL DAY

094X Other Therapeutic Services (also see 095x, an extension of 094x)

Charges for other therapeutic services not otherwise categorized.

	Subcategory	Standard Abbreviation
1	Recreational Therapy **(Not payable)**	RECREATION RX
2	Education/Training	EDUC/TRAINING
3	Cardiac Rehabilitation	CARDIAC REHAB
4	Drug Rehabilitation	DRUG REHAB
5	Alcohol Rehabilitation	ALCOHOL REHAB
6	Complex Medical Equipment – Routine **(Not payable)**	CMPLX MED EQUIP – ROUT

	Subcategory	Standard Abbreviation
7	Complex Medical Equipment – Ancillary **(Not payable)**	CMPLX MED EQUIP – ANC
9	Other Therapeutic Services (written description required)	ADDITIONAL RX SVS

095X Other Therapeutic Services (an extension of 094x) - NOT COVERED

	Subcategory	Standard Abbreviation
1	Athletic Training (**Not covered**)	ATHLETIC TRAINING
2	Kinesiotherapy (**Not covered**)	KINESIOTHERAPY
3-9	RESERVED	

096X Professional Fees (also see 097x and 098x)

Charges for medical professionals that the institutional health care provider, along with the third-party payer, require the professional fee component to be billed on the UB. The professional fee component is separately identified by this revenue code. Generally used by Critical Access Hospitals (CAH) who bill both the technical and professional service components on the UB.

	Subcategory	Standard Abbreviation
1	Psychiatric	PRO FEE/PSYCH
2	Ophthalmology	PRO FEE/EYE
3	Anesthesiologist (MD)	PROF FEE/ANEST MD
4	Anesthetist (CRNA) **(Not payable)**	PROF FEE/ANEST CRNA
9	Other Professional Fees (written description required)	PRO FEE/OTHER

097X Professional Fees (Extension of 096x)

	Subcategory	Standard Abbreviation
1	Laboratory	PRO FEE/LAB
2	Radiology – Diagnostic	PRO FEE/RAD/DX
3	Radiology – Therapeutic	PRO FEE/RAD/RX
4	Radiology – Nuclear	PRO FEE/NUC MED
5	Operating Room	PRO FEE/OR
6	Respiratory Therapy	PRO FEE/RESPIR
7	Physical Therapy (**Not payable)**	PRO FEE/PHYSI
8	Occupational Therapy **(Not payable)**	PRO FEE/OCCUPA
9	Speech Therapy **(Not payable)**	PRO FEE/SPEECH

098X **Professional Fees (Extension of 096x and 097x)**

Charges for medical professionals that the institutional health care provider, along with the third-party payer, require the professional fee component to be billed on the UB. The professional fee component is separately identified by this revenue code. Generally used by Critical Access Hospitals (CAH) who bill both the technical and professional service components on the UB.

	Subcategory	Standard Abbreviation
1	Emergency Room Services	PRO FEE/ER
2	Outpatient Services	PRO FEE/OUTPT
3	Clinic	PRO FEE/CLINIC
4	Medical Social Services **(Not payable)**	PRO FEE/SOC SVC
5	EKG	PRO FEE/EKG
6	EEG	PRO FEE/EEG
7	Hospital Visit **(Not payable)**	PRO FEE/HOS VIS
8	Consultation **(Not payable)**	PRO FEE/CONSULT
9	Private Duty Nurse **(Not payable)**	PRO FEE/PVT NURSE

099X **Patient Convenience Items – NOT PAYABLE**

100X **Behavioral Health Accommodations - NOT COVERED**

Charges for routine accommodations at specified behavioral health facilities.

	Subcategory	Standard Abbreviation
10	General Classification **(Not covered)**	BH R&B
1	Residential Treatment – Psychiatric **(Not covered)**	BH R&B RES/PSYCH
2	Residential Treatment – Chemical Dependency **(Not covered)**	BH R&B RES/CHEM
3	Supervised Living **(Not covered)**	BH R&B SUP LIVING
4	Halfway House **(Not covered)**	BH R&B HALWAY HOUSE
5	Group Home **(Not covered)**	BH R&B GROUP HOME

101X to 209X **RESERVED**

210X **Alternative Therapy Services - NOT COVERED**

Charges for therapies not elsewhere categorized under other therapeutic service revenue codes (042X, 043X, 044X, 091X, 094, 095X) or services such as anesthesia or clinic (0374, 0511).

	Subcategory	Standard Abbreviation
0	General Classification **(Not covered)**	ALTTHERAPY
1	Acupuncture **(Not covered)**	ACUPUNCTURE
2	Acupressure **(Not covered)**	ACUPRESSURE
3	Massage **(Not covered)**	MASSAGE

	Subcategory	Standard Abbreviation
4	Reflexology **(Not covered)**	REFLEXOLOGY
5	Biofeedback **(Not covered)**	BIOFEEDBACK
6	Hypnosis **(Not covered)**	HYPNOSIS
9	Other Alternative Therapy Service (written description required) **(Not covered)**	OTHER ALTTHERAPY

Notes:
Alternative therapy is intended to enhance and improve standard medical treatment. These revenue codes would be used to report services in a separately designated alternative inpatient/outpatient unit.

211X to 309X **RESERVED**

310X **Adult Care - NOT COVERED**

Charges for personal, medical, psycho-social, and/or therapeutic services in a special community setting for adults needing supervision and/or assistance with Activities of Daily Living (ADL).

	Subcategory	Standard Abbreviation
1	Adult Day Care, Medical and Social Hourly **(Not covered)**	ADULT MED/SOC HR
2	Adult Day Care, Social – Hourly **(Not covered)**	ADULT SOC HR
3	Adult Day Care, Medical and Social – Daily **(Not covered)**	ADULT MED/SOC DAY
4	Adult Day Care, Social – Daily **(Not covered)**	ADULT SOC DAY
5	Adult Foster Care Daily **(Not covered)**	ADULT FOSTER DAY
9	Other Adult Day Care (written description required) **(Not covered)**	OTHER ADULT

311X to 999X **RESERVED**