MARYLAND MEDICAID

NURSING FACILITY SERVICES

UB-04 BILLING INSTRUCTIONS

Issued: February 5, 2013

Applicable for Dates of Service beginning July 1, 2012

UB-04 BILLING INSTRUCTIONS FOR NURSING FACILITY SERVICES

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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.

COMPLETION OF UB-04 FOR NURSING FACILITY SERVICES

INTRODUCTION

The uniform bill for institutional providers is known as the UB04 and is the replacement for the UB92 form. Starting July 30, 2007 all institutional paper claims must use the UB04; the UB92 will no longer be acceptable after this date.

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 at:
http://www.dhmh.state.md.us/hipaa/transandcodesets.html

The UB04 is a uniform institutional bill suitable for use in billing multiple third party liability (TPL) payers. When submitting the above claims, complete all items required by each payer who is to receive a copy of the form.

The Department will reimburse providers for nursing facility services for all medically necessary days and Administrative Days which have been approved by the Department's utilization control agent.

BILLING TIME LIMITATIONS

Invoices must be received within twelve (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 month of service, whichever is longer. 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.

OTHER THIRD-PARTY RESOURCES

All other third-party resources 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 9-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.

PAPER INVOICES

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.

Completed invoices are to be mailed to the following address:

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

ADJUSTMENTS

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 DHMH-4518A, Adjustment Form and mail that form to the address below:

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

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

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

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

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

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23		PAGE _____ OF _____	CREATION DATE		TOTALS			23

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

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

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

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

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

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

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

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

UB-04 CMS-1450

OMB APPROVAL PENDING
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 UB04 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 facility. 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 facility 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.

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. Only those frequency codes highlighted in grey can be used for Maryland Medicaid Nursing Facility claims.

Type of Bill **Do NOT report leading zero**	**Description**	**Inpatient/Outpatient General Designation**
0**21x**	Skilled Nursing – Inpatient (Including Medicare Part A)	IP

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
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
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.
7	Replacement of Prior Claim **(Future)**	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**)	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.

Note: Frequency codes "7" and "8" 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.

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

Required. Enter the "From" and "Through" dates covered by the services on the invoice (MMDDYY). The "Through" date equals the date through which we are paying for services. Remember that Medical Assistance does not pay for services for the date of death/discharge. The date of death/discharge should never be shown as the through date in this field.

NOTE A: If the nursing home is reporting revenue code 0185 - Hospital Leave on the date of death, then the date of death may be reported in the "through" field and Medical Assistance will pay for services for this day. This is the only occurrence in which Medical Assistance will pay for the date of death/discharge.

NOTE B: Medicare Part A and Part B claims should include the "From" and "Through" dates as indicated on the Medicare payment listing or EOMB.

FL 07 **Reserved for Assignment by NUBC – NOT USED**

FL 08a **Patient Name – Identifier**

Not Required.

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.)

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

Not Required.

FL 10 **Patient Birth Date**

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

FL 11 **Patient Sex**

Not required.

FL 12 **Admission/Start of Care Date**

Required. Enter the start date for this episode of care. For nursing home services, this is the date of admission. Enter the Admission/Start of Care Date as (MMDDYY).

FL 13 **Admission Hour**

Not required.

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

Required. 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 from an 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.

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

Required. Enter the code indicating the source of the referral for this admission or visit.

Code Structure: Source of Referral for Admission or Visit		
1	Physician Referral	The patient was admitted to this facility upon the recommendation of his or her personal physician.
2	Clinic Referral	The patient was admitted to this facility upon recommendation of a clinic's physician.
3	HMO Referral	The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.
4	Transfer from a Hospital	Transfer from a hospital
5	Transfer from a Skilled Nursing Facility	The patient was admitted to this facility as a transfer from a skilled nursing facility where he or she was a resident.
6	Transfer from Another Health Care Facility	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.
8	Court/Law Enforcement	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.

Code Structure: Source of Referral for Admission or Visit		
9	Information not Available NOT USED	The means by which the patient was admitted to this nursing facility is not known.

FL 16 **Discharge Hour**

Not Required.

FL 17 **Patient Discharge Status**

Required. A code indicating the disposition or discharge status of the patient at the end of service for the period covered on this bill, as reported in FL6, Statement Covers Period.

Enter code from code structure below indicating the patient's disposition at the time of billing for that period of inpatient care.

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 covered skilled care.
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	Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List. Usage Notes: Designated cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such facilities. **Definition effective 10/1/07:** Discharged/transferred to a Designated Cancer Center or Children's Hospital
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
20	Expired
30	Still a patient

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
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 10/1/07: **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**

Not required.

FL 29 **Accident State**

Not required.

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).

Note: 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 Value Codes, including those reported in FL 81.

Enter the appropriate codes and dates from the table below.

Code Structure – Occurrence Codes & Dates:		
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the facility 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.
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.

<u>FL 35-36a b</u> Occurrence Span Codes and Dates

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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.
75	Administrative Day Dates	Administrative Day Code and Span. These days must be billed under the Administrative Day revenue code, 0169, in FL42
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.

Note: Code 75 must be used when billing for Administrative Days. Therefore, in FL35 enter Code 75 and the span dates covered under FROM and THROUGH. These days **must** be reported under the Administrative Day Revenue Code, 0169, in FL42.

Administrative Day span data will be given to the Program's Utilization Control Agent (UCA) along with the other data they receive from the monthly claim as part of the patient assessment process. The UCA will check to see if documentation for Administrative Days exists for the days entered on the claim. If the documentation for Administrative Days does not exist or is not acceptable, the days will be adjusted as appropriate through the patient assessment process.

FL 37 **NOT USED**

FL 38 **Responsible party name and address**

Not 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.

Enter Value Codes in alphanumeric sequence. 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 12 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.

[(a)]*Do not use on v. 004010/004010A1 837 electronic claims (use Claim Quantity in Loop ID 2300 | QTY01 instead).*

Note: Code 80 replaces UB form locator for covered days. This value code must be entered, showing the number of level of care days billed.

FL 42 **Revenue Codes**

Required. Line 1-23. Enter the appropriate four-digit revenue code in FL 42 from the chart below to identify specific level of care and ancillary charges. Please note that there are two revenue codes for Tube Feeding – Medicaid, Decubitus Ulcer Care – Medicaid and Negative Pressure Wound Therapy.

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 charges on the final claim page only indicated using Revenue Code 0001.

- **Note: Each revenue code may only be used only once. If Decubitus Ulcer care and Negative pressure wound therapy are billed on the same day, bill only one day of revenue code 0550 – Skilled Nursing General.** Enter only one code each for Physical, Occupational and Speech therapy and enter the number of 15 minute units. The maximum per day per therapy is 4 units – one hour.

REVENUE CODES - FL 42			
COMAR DESCRIPTION	**REVENUE CODE DESCRIPTION**	**REVENUE CODE**	**UNITS**
DAYS OF CARE			
Days of Care Light	Rm & Brd Semi-Private - General	**0120**	
Days of Care Moderate	Rm & Brd Semi-Private - Other	**0129**	
Days of Care Heavy	Subacute Care-General	**0190**	
Days of Care Heavy Spec	Subacute Care-Other	**0199**	
Therapeutic Home Leave	Leave of Absence – Therapeutic Lv.	**0183**	
Coinsurance Days	All Inclusive Rm & Brd	**0101**	
Administrative Day	Administrative Day	**0169 with code 75 and span in FL36**	
ADDITIONAL NURSING SERVICES			
Class A Support Surface	Durable Medical Equipment – General	**0290**	
Class B Support Surface	Durable Medical Equipment – Other	**0299**	
Bariatric Bed - A	Complex Medical Equipment	**0946**	
Bariatric Bed - B	Durable Medical Equipment	**0291**	
Oxygen	Respiratory – Inhalation Services	**0412**	
Suctioning/Tracheotomy Care	Respiratory – General	**0410**	
Intensive Tracheotomy Care	Respiratory – Complex	**0413**	
Ventilator Care	Respiratory – Other	**0419**	
IV - Central Line	IV Therapy – Other	**0269**	
Peripheral IV	IV Therapy – General	**0260**	
Turning and Positioning	Incremental Nursing – General	**0230**	
Tube Feeding - Medicaid **(note that this procedure crosswalks to 2 revenue codes)**	Skilled Nursing – Other Medical/Surgical Supplies - Other	**0559** **0279**	
Tube Feeding - Medicare	Skilled Nursing – Other	**0559**	
Decubitus Ulcer Care - Medicaid **(note that this procedure crosswalks to 2 revenue codes)**	Skilled Nursing – General Medical/Surgical Supplies - Sterile	**0550** **0272**	
Decubitus Ulcer Care - Medicare	Skilled Nursing – General	**0550**	
Negative Pressure Wound Therapy **(note that this procedure crosswalks to 2 revenue codes)**	Skilled Nursing – General Medical/Surgical Supplies – General	**0550** **0270**	

THERAPY SERVICES			
Physical Therapy 1/4 hour	Physical Therapy – General	**0420**	1 unit per day
Physical Therapy 1/2 hour	Physical Therapy – General	**0420**	2 units per day
Physical Therapy 3/4 hour	Physical Therapy – General	**0420**	3 units per day
Physical Therapy 1 hour	Physical Therapy – General	**0420**	4 units per day
Occupational Therapy 1/4 hour	Occupational Therapy - General	**0430**	1 unit per day
Occupational Therapy 1/2 hour	Occupational Therapy - General	**0430**	2 units per day
Occupational Therapy 3/4 hour	Occupational Therapy - General	**0430**	3 units per day
Occupational Therapy 1 hour	Occupational Therapy - General	**0430**	4 units per day
Speech Therapy 1/4 hour	Speech Therapy – General	**0440**	1 unit per day
Speech Therapy 1/2 hour	Speech Therapy – General	**0440**	2 units per day
Speech Therapy 3/4 hour	Speech Therapy – General	**0440**	3 units per day
Speech Therapy 1 hour	Speech Therapy – General	**0440**	4 units per day

FL 43 **Revenue Descriptions**

Not required.

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

Not required.

FL 45 **Service Date**

Line 1-22:
Not required.

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 **Service Units**

Required. Enter the number of days or units of service on the line adjacent to the revenue code. There must be days or units of service for every revenue code except 0001.

Sum the units for the therapy revenue codes**.**

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).

FL 48 **Non-Covered Charges**

Not required.

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.

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

Not required.

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

Not required.

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.

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

Required. The unique identification number assigned to the provider submitting the bill; NPI is the10-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 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 **Other (Billing) Provider Identifier – Legacy**

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

The UB04 does not use a qualifier to specify the Other (Billing) Provider Identifier. Use this field to report other provider identifiers as assigned by the health plan (as indicated in FL50 Lines a-c).

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

Not required.

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

Not required.

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

Required. Enter the Medical Assistance number of the insured as it appears on the Medical Assistance card.

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.

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

Not required.

FL 63 a,b,c Treatment Authorization Code

Not required.

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.

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

Not required**.**

FL 67 Principal Diagnosis Code and Present on Admission Indicator

Principal Diagnosis Code

Not required. Enter the 5-digit ICD-9-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 UB04.

Follow the official guidelines for ICD reporting. Refer to the Official ICD-9-CM Guidelines for Coding and Reporting for additional information.

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

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

FL 67 a-q Other Diagnosis Codes

Not required.

FL 68 Reserved for Assignment by NUBC – NOT USED

FL 69 **Admitting Diagnosis**

Not required.

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

Not required.

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

Not required.

FL 72 a-c **External Cause of Injury Code (ECI or E-Code)**

Not required.

FL 73 **Reserved for Assignment by NUBC – NOT USED**

FL 74 **Principal Procedure Code and Date**

Not Required

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

Not Required.

FL 75 **Reserved for Assignment by NUBC – NOT USED**

FL 76 **Attending Provider Name and Identifiers**

Not Required.

Line 1 Not required.

Line 1 Secondary Identifier Qualifiers: Not required.

Line 2 Attending Physician Name
Not Required.

FL 77 **Operating Physician Name and Identifiers**

Not required.

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

Not required.

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

Not required.

FL 80 **Remarks**

Not required.

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. Please refer to Code List Qualifer B3 – Taxonomy Codes.

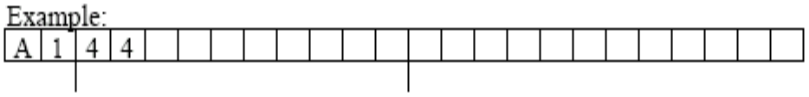
Left Column:	Middle Column:	Right Column:
1 field (Code Qualifier)	1 field (Code)	1 field (Number or Value)

Notes

Code List Qualifiers:

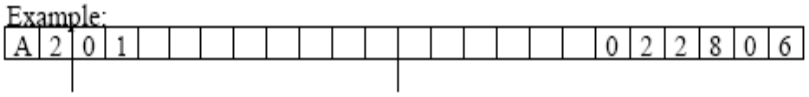
01-A0	Reserved for National Assignment
A1	National Uniform Billing Committee Condition Codes (FL 18-28) Right column is blank.

Example:



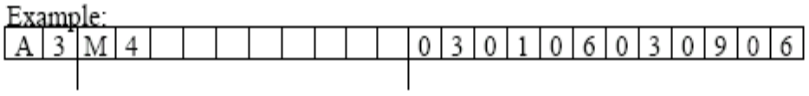
A2	National Uniform Billing Committee Occurrence Codes (FL 31-34)

Example:



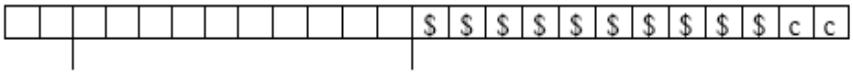
A3	National Uniform Billing Committee Occurrence Span Codes (FL 35-36) All positions fully coded in the right column.

Example:



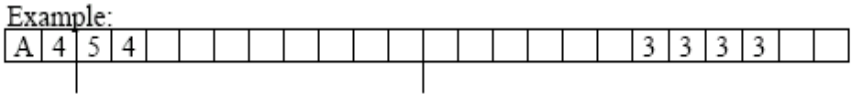
Notes: Code List Qualifiers (Con't)

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.



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:

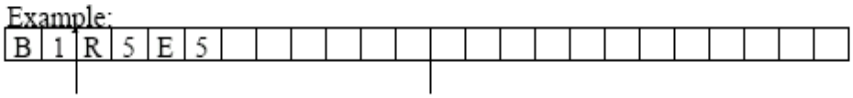


A5-B0 Reserved for Assignment by the NUBC.

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:



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.

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

Specialty	Bill Type(s)	Subspecialties	Taxonomy Code
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											