MARYLAND MEDICAID
UB-04 BILLING INSTRUCTIONS

HOME HEALTH SERVICES

THESE INSTRUCTIONS ARE FOR PAPER CLAIMS ONLY

Rev. 5/07

UB-04 Home Health Billing Instructions

NOTE: These billing instructions are for billing paper claims only.

For information on electronic billing, please refer to Home Health section of the National Electronic Data Interchange Transaction Set Implementation Guide, Health Care Claim: Institutional 837.

BILLING TIME LIMITATIONS

Invoices must be received within nine (9) months of the month of service on the invoice. If a claim is received within the 9-month limit but rejected, resubmission will be accepted within 60 days of the date of rejection or within 9 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.

It is preferred that invoices be typed. If printed, the entries must be legible and in black or blue ink only. Do not use pencil or a red pen to complete the invoice. Otherwise, payment may be delayed or the claim rejected. The instructions that follow are keyed to the form locator number and headings on the UB-04 form.

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 should be completed when a specific bill has been issued for a specific provider, patient, payer, insured and "statement covers period" dates(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

The following instructions are keyed to the form locator numbers and headings on the UB-04 form.

FL01 **Billing provider name, address, zip code 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 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 - Enter provider area code and phone number (optional).

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

FL02 **Pay to Name & Address**

Leave Blank – Internal Use Only

FL03 a **Patient Control Number**

Required. Enter the patient's control number assigned to the patient by the provider. A maximum of 20 positions will be returned on the remittance advice to the provider. The provider should assign each patient a unique number.

FL03 b **Medical Health/Record Number**

Not required.

FL04 **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. All three digits are required to process a claim. **Use Type of Bill 331 for home health services.**

FL05 **Federal Tax Number**

Not required.

FL06 **Statement Covers Period (From - Through)**

Required. Enter the "From" and "Through" dates covered by the services on the invoice (MMDDYY). Statement covers period dates must match the dates reflected in field 45.

FL07 **Reserved for Assignment by NUBC - Not Used**

FL08 b **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.)

FL09 **Patient Address**

Optional.

FL10 **Patient Birth Date**

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

FL11 **Patient Sex**

Not required.

FL12 **Admission/Start of Care Date**

Not required.

FL13 **Admission Hour**

Not required.

FL14 **Type of Admission**

Not required.

FL15 **Source of Admission**

Not required.

FL16 **Discharge Hour**

Not required.

FL17 **Patient Status**

Not required.

FL18-28 **Condition Codes**

Not required.

FL29 **Accident State**

Not required.

FL30 **Reserved for Assignment by NUBC** - Not Used

FL31-34 a-b **Occurrence Codes and Dates**

Use code "25" if applicable. That is, code 25 indicates a third party liability denial other than Medicare.

FL35-36 a-b **Occurrence Span Codes and Dates**

Not required.

FL37 **Not Used**

FL38 **Responsible party name and address**

Not required.

FL39-41 a-d **Value Codes and Amounts**

Not required.

FL42 **Revenue Codes – Required**

Enter the appropriate four-digit revenue code from the Revenue Code Matrix chart shown below. To assist in bill review, revenue codes should be listed in ascending numeric sequence with the exception of "0001 - Total Charge" which is used on paper claims only and is reported on Line 23 of the last page of 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.

NOTE: Each revenue code may be used more than once when billing with a date of service. Line item billing methodology is correct.

REVENUE CODE	DESCRIPTION
0551	Home Health Skilled Visiting Nurse
0559	Skilled Nursing Visits (other)
0571	Home Health Aide Visit
0421	Home Health Physical Therapy Visit
0431	Home Health Occupational Therapy Visit
0441	Home Health Speech Language Pathology Visit
0273	Home Health Medical Supplies

FL43 **Revenue Descriptions**

Not required.

FL44 **HCPCS/RATES Accommodation/HIPPS Rate Codes**

Not required.

FL45 **Service Date**

Line 1-22:
Required. Enter the service date as "MMDDYY". All requested dates must be within "from thru dates" in FL06.

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.

FL46 **Units of Service**

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

FL47 **Total Charges**

Total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period (FL 06).

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).

FL48 **Non-Covered Charges**

Not required.

FL49 **Untitled**

Not required

FL50 a,b,c **Payer Identification**

Optional.
First line, 50A, is the Primary Payer Name. Second Line, 50B, is Secondary Payer Name. Third line, 50C, is Tertiary Payer Name. Multiple payers should be listed in priority sequence according to the priority the provider expects to receive payment from these payers.

NOTE: Medicaid should be the last entry in this field if other payers are listed.

FL51 a,b,c **Health Plan Identification Number**

Not required.

FL52 a,b,c **Release of Information Certification Indicator**

Not required.

FL53 a,b,c **Assignment of Benefits Certification Indicator**

Not required.

FL54 a,b,c **Prior Payments - Payer and Patients**

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.

NOTE: Do not report Medicare's payment in this field.

FL55 a,b,c **Estimated Amount Due**

Not required.

FL56 **National Provider Identification (NPI)**

Enter the unique identification Billing Provider number assigned to the provider submitting the bill; NPI is the 10-digit national provider identifier.

FL57 **Other (Billing) Provider Identifier (Legacy)**

Enter the 9 digit Maryland Medicaid Legacy Provider Identification number.

FL58 a,b,c **Insured's Name**

Not required.

FL59 a,b,c **Patient Relationship to Insured**

Not required.

FL60 **Insured's Unique ID**

Enter the 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.

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

Baltimore Metropolitan Area: (410) 333-3020
Toll-Free Long Distance: 1-866-710-1447

Web EVS: 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

FL61 a,b,c **Insured's Group Name**

Not required.

FL62 a,b,c **Insurance Group Number**

Not required.

FL63 **Treatment Authorization Codes**

Enter the preauthorization number when appropriate.

FL64 a,b,c **Internal Control Number (ICN)/Document Control Number (DCN)**

Not required.

FL65 **Employer Name**

Not required.

FL66 **Diagnosis and Procedure Code Qualifier (ICD Version Indicator)**

Not required.

FL67 **Principal Diagnosis Code**

Enter the full ICD-9-CM code describing the principal diagnosis.

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

FL67-a-q **Other Diagnosis Codes**

Optional.

Enter the ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist.

FL68 **Reserved for Assignment by NUBC - Not Used**

FL69 **Admitting Diagnosis**

Not required.

FL70 a,b,c **Patient's Reason for visit Code**

Not Required.

FL71 **Prospective Payment System (PPS) Code**

Not Required.

FL72 a-c **External Cause of Injury Code (E-Code)**

Not required.

FL73 **Reserved for Assignment by NUBC - Not Used**

FL74 **Principal Procedure Code and Date**

Not required.

FL74 a-e **Other Procedure Codes and Dates**

Not required.

FL75 **Reserved for Assignment by NUBC - Not Used**

FL76 **Attending Physician Identification Number**

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 Outpatient: **Required.** Enter the 10-digit NPI number assigned to the patient's attending physician.

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

FL77 **Operating Physician Name and Identifiers**

Not required.

FL 78-79 **Other Provider (Idividual) Names and Identifiers**

Not required.

FL80 **Remarks**

Not required

FL81 a-d **Code – Code Field**

Not Required.