MARYLAND MEDICAL ASSISTANCE PROGRAM

UB-04

BILLING INSTRUCTIONS
FOR
INTERMEDIATE CARE FACILITIES-ADDICTIONS

July 30, 2007

Rev. 6/19/07

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COMPLETION OF UB-04 FOR INTERMEDIATE CARE FACILITY ADDICTION SERVICES

The uniform bill for institutional providers is known as the UB-04 and is the replacement for the UB-92 form. Starting July 30, 2007 all institutional paper claims must use the UB-04; the UB-92 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 UB-04 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.

Intermediate Care Facilities-Addictions services are billed on a UB-04. The instructions for billing on the UB-04 will be mailed with the provider application forms. Providers are required to bill one calendar month of service per invoice. Use Revenue code **0100** to bill for the residential services. Billing questions or requests for more specific information should be directed to the Institutional Hotline at 410-767-5457. Policy questions should be directed to the staff specialist for ICF-As, Venus Lee at 410-767-1737.

The Maryland Medicaid statute of limitations for timely claim submission is as follows: Invoices for ICF-A services must be received within 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 date of discharge (or month of service), whichever is the longer period. 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 9 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 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.

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 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	ADMISSION 12 DATE	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

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

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

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
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 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

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

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

80 REMARKS	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 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.

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 Intermediate Care Facility-Addiction claims.***

Type of Bill **Do NOT report leading zero**	**Description**	**Inpatient/Outpatient General Designation**
0**65x**	Intermediate Care Facility – Addictions	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 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.

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 No. Required**

Not required.

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

Required. Enter the "From" and "Through" dates covered by the services on the invoice (MMDDYY). Your facility may not bill for two separate months on one claim form.

NOTE A: "Split" billing. An ICF-A may not "split" a Medical Assistance bill for services rendered during one calendar month unless there is a gap in the patient's eligibility during the month that results in a new admission.

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**

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/Start of Care Date**

Required on all inpatient claims**.** Enter the start date for this episode of care (MMDDYY). For inpatient services, this is the date of admission. Enter the Admission/Start of Care Date as (MMDDYY). ***ICF-A facilities 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. Enter the code for the hour during which the patient was admitted for inpatient 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.)

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

Required for all inpatient admissions except for bill type 021x. Enter the code indicating the source of the referral for this admission or visit. Optional for outpatient claims.

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.
2	Clinic Referral	Inpatient: The patient was admitted to this facility upon recommendation of this facility's clinic physician.
3	HMO Referral	Inpatient: The patient was admitted to this facility upon the recommendation of a health maintenance organization physician.
4	Transfer from a Hospital (Different Facility)	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.
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.
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.
7	Emergency Room	Inpatient: The patient was admitted to this facility upon the recommendation of this facility's emergency room physician.
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.
9	Information not Available NOT USED	Inpatient: The means by which the patient was admitted to this hospital is not known.

FL 16 **Discharge Hour**

Not required.

FL 17 **Patient Status Required**

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.

Code Structure:

01 - Discharged to self or home care (routine discharge)
02 - Discharged/transferred to another short-term general hospital for inpatient care.
03 - Discharged/transferred to skilled nursing facility (SNF).
04 - Discharged/transferred to an intermediate care facility (ICF)
05 - Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List (i.e., designated cancer hospitals & children's hospitals).
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.
07 - Left against medical advice or discontinued care.
20 - Expired
30 - Still a patient
43 - Discharge/Transferred to a Federal Healthcare 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 **Definition effective 10/1/07:**
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 all dates as MMDDYY. Enter the appropriate Medical Assistance Occurrence Code and Date defining a significant event relating to this bill from the table below.

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 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:		
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.
42	Date of Discharge	Use only when "Through" date in FL 6 (Statement Covers Period) is not the actual discharge date and the frequency code in FL 4 is that of a final bill (1 or 4).

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:		
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.

Code 74:
- Code 74 is to be used 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.***

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.

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.
81[(a)]	Non-Covered Days	Days of care not covered by the primary payer.

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

Note: Codes 80, and 81 must be submitted showing the number of covered and non-covered days when applicable.

FL 42 **Revenue Codes**

Line 1. Enter the four-digit numeric revenue code **0100,** All Inclusive Room and Board Plus Ancillary**.**

Line 23 - 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**.

To assist in bill review, revenue codes should always be listed in ascending numeric sequence. 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. Accommodations must be entered first on the bill and in revenue code sequence. Revenue codes must not be repeated on the same bill.

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 **Units of Service**

Required. Enter the total number of ***covered*** accommodation days, 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.

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

Total (Summary) Charges
Required on 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**

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

Line Item Non-Covered Charges
Required if needed to report line specific non-covered charge amounts. 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) Non-Covered Charges
Required on 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 Code 74, Leave of Absence Dates in FL35.

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 Certificate Indicator

Not required

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

Not required

FL 54 a,b,c Prior Payments - Payer

The amount the provider has received (to date) by the health plan toward payment of this bill.

Enter the amount paid by the health plan on lines a, b, or c according to Payer Name(s) in FL 50.

DO NOT REPORT MEDICARE PRIOR PAYMENTS IN THIS FIELD.

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 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.

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 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.

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)**

Not required.

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

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 UB-04.

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

The ICD-9-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.

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

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

Required. Enter the 5-digit ICD-9-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-9-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.

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)/POA Indicator**

Not required.

FL 73 **Reserved for Assignment by NUBC**

Not used.

FL 74 **Principal Procedure Code and Date**

Not required for ICF-A facility billing.

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

Not required for ICF-A facility billing.

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: Enter the 10-digit NPI number required by the Centers for Medicare & Medicaid Services (CMS) for the physician attending an inpatient. This is the physician primarily responsible for the care of the patient from the beginning of this hospitalization.

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

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.

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

Notes: Code List Qualifiers:

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

Used for Billing Provider only. Use the appropriate taxonomy code accompanying for the age groups indicated. You must submit the accompanying designated taxonomy code listed to assure appropriate reimbursement from the Medical Assistance Program.

Specialty	**Bill Type(s)**	**Subspecialties**	**Taxonomy Code**
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											