UB-04, Inpatient / Outpatient

Hospital (Inpatient and Outpatient), Hospice (Nursing Home and Home Services), Home Health, Rural Health Clinic, Federally Qualified Health Center, ICF/MR, Birthing Center, and LTC/Nursing Homes must bill on a UB-04.

Atypical providers are providers who do not provide medical service and therefore are exempt from obtaining and billing with a NPI. All other providers are required to bill with their NPI.

UB-04 Instructions
The blocks divided into rows A, B, C reflect the following:

A Primary Payer
B Secondary Payer
C Tertiary Payer

All information in field 50, 54, 60, and 63 should follow the instructions listed below:

Line A applies to payer A
Line B applies to payer B
Line C applies to payer C

Field Requirements:
Blank = Not Required
C Conditionally Required
R Required Field including Nursing Home
RI Required Inpatient
RO Required Outpatient
RNH Required Nursing Home

**Note – All requirements will be enforced on January 1, 2015. Failure to comply could result in claim rejections.

Form Locator	Required Field	Field Name	Comments
1	R	Provider Name, Address, Phone number	Enter the name, address, and phone number of the Billing provider. Address includes: street address, city, state and 9 digit zip code.
2	C	Service Facility Name, Address, and ID	Enter the Service Facility Location's name and address. Enter the Service Facility ID as: Provider 10 digit NPI, dash, 3 digit facility code. OR Provider 10 digit Medicaid ID, dash, 3 digit facility code. Example: 0123456789-123 (no spaces).

3A	R	Patient Control Number	Alphanumeric characters may be used (Maximum of 20). The patient account number is printed on the remittance advice.
3B		Medical Record Number	Alphanumeric characters may be used (Maximum of 20). The medical record number is **not** printed on the remittance advice.
4	R	Type of Bill	Enter 0 then the appropriate 3 digit code for type of bill. Valid values are: 11x = Hospital Inpatient (Including Medicare Part A) 12x = Hospital Inpatient (Medicare Part B Only) 13x = Hospital Outpatient 14x = Hospital Other 18x = Hospital Swing Beds 21x = SNF Inpatient (Including Medicare Part A) 22x = SNF Inpatient (Medicare Part B Only) 23x = SNF Outpatient 28x = SNF Swing Bed 32x = Home Health 34x = Home Health 71x = Rural Health Clinic 72x = Outpatient ESRD 73x = Federally Qualified Health Center (FQHC) 74x = Outpatient Rehab Clinic 77x = Federally Qualified Health Center (FQHC) 81x = Hospice 82x = Hospice/Hospital Center 83x = Ambulatory Surgery Center 84x = Birthing Center 85x= Critical Access 89x = Inpatient Residential Treatment Center

			"X" indicates frequency. Valid values are: 0 = Zero Claim 1 = Admit thru Discharge 2 = Interim Bill - First Claim 3 = Interim Bill - Cont Claim 4 = Interim Bill - Final Claim 5 = Late Charge Only Claim 7 = Prior claim/Replacement 8 = Cancel of Prior Claim 9 = Final claim for a Home Health PPS episode *Please note: Values 2, 3, & 4 cannot be used on acute care hospital claims.* *If the frequency code indicates an adjustment of a prior claim (7, 8), the original claim ID (as assigned by Medicaid or CHIP), must be referenced in field 64.*
5	R	Federal Tax ID	Enter numeric 9 digit Federal Tax ID.
6	R	Statement Covers Period From - Through	Enter the dates of service covered by the Claim. Enter each date as MMDDCCYY or MMDDYY ***Note: Inpatient dates of service must reflect the date of admission thru date of discharge unless claim is interim bill. Acute Care Hospitals may not bill interim claims.*** ***Outpatient hospital (not including CAH) claims spanning June 30 thru July 1 and September 30 thru October 1) cannot be billed on the same claim.***
7			No entry required.
8A	R	Patient ID	Enter patient 11-digit MAID number exactly as it appears on the patient's WV Medicaid ID card
8B	R	Patient Name	Enter patient last, first name
9A	R	Patient Address	Enter Address
9B	R	City	Enter City
9C	R	State	Enter State
9D	R	Zip Code	Enter 9 digit Zip Code
9E	C	Country Code	No entry required
10	R	Birth Date	Enter the patient's date of birth. Must be valid date and format MMDDCCYY.
11	R	Sex	Enter the patient's gender code: M (male), F (female), or U (unknown).
12	RI, RNH	Admission Date	Enter the date that the patient was admitted to the facility. Must be valid date and format MMDDYY or MMDDCCYY.

13	RI, RNH	Admission Hour	Enter the 2 digit hour the patient was admitted using the military hour. Valid values are 00 – 23.
14	RI, RNH	Type of Admission	Enter 1 digit admission type code. Valid values are 1, 2, 3, 4, or 9.
15	R	Source of Admission	Enter 1 digit admission source. Valid values are 1 – 9. **Required for all inpatient and outpatient services.
16	RI, RNH	Discharge Hour	Enter 2 digit hour the patient was discharged using the military hour. Valid values are 00 – 23.
17	R	Patient Status	Enter 2 digit patient status code. Valid values are 00 – 99. **Note: 5010 does not allow a 'blank' for patient status. We will default to '01' until 12/31/2014 and then all 'blanks' will reject. *'01' = Discharged to home or selfcare (routine discharge)*
	C	Condition Codes	Enter if applicable. ***Note: Nursing Homes & ICF/MR's and hospice providing services within the nursing home: Effective July 1, 2018 "M1" condition code will be replaced with "D3" value code when billing a partial patient resource amount for Nursing Homes & ICF/MR's. For 90 days, Gainwell Technologies' system will accept "M1" as a condition code and value code "31" that was previously used and will return a WARN status on remittance advices. Effective October 1, 2018 claims will DENY unless billed with a "D3" value code. This change is being made due to HIPAA compliance requirements*** ***Note: Use Condition Code 44 on Outpatient claims only, when the physician ordered IP services but upon internal utilization review performed before the claim was originally submitted the hospital determined the services did not meet Medicaid Medical inpatient criteria.***
29		Accident State	No entry required.
30			No entry required.

31-34	C RNH	Occurrence codes and dates	Enter the appropriate Occurrence Codes and valid dates (format MMDDCCYY) beginning with 31a and entering horizontally through 34a. When needed, continue entering codes and dates using 31b-34b listing them horizontally. **For Nursing Homes:** A3- Benefits exhausted 22- Date active care ended **For Inpatient Hospital**: See instructions for billing no PART A at the end of the UB Billing instructions.
35-36	C	Occurrence Span	For Inpatient only: Enter the appropriate Occurrence Span (format MMDDCCYY) beginning with 35a and entering horizontally through 36a. When needed, continue entering spans using 35b and 36b listing them horizontally.
37			No entry required.
38		Responsible Party Name and Address	No entry required.

39-41	C	Value Codes and Amounts	Enter the appropriate value code(s) with the corresponding amount(s). The first value code and amount are entered in block 39a. The second through twelfth value codes and amounts are entered in 40a, 41a, 39b, 40b, etc. ***Note: Nursing Homes & ICF/MR's and hospice providing services within the nursing home. Effective July 1, 2018 enter D3 when billing a partial patient resource and report the amount in 31 for Nursing Homes & ICF/MR's. Hospice Nursing Home requires patient resource "D3" to be reported on all claims. For 90 days, Gainwell Technologyies' system will accept "M1" as a condition code and value code "31" that was previously used and will return a WARN status on remittance advices. Effective October 1, 2018 claims will DENY unless billed with a "D3" value code. This change is being made due to HIPAA compliance requirements*** Valid values are: 06= Blood Deductible A1 = Deductible Payer A B1 = Deductible Payer B C1 = Deductible Payer C A2 = Coinsurance Payer A B2 = Coinsurance Payer B C2 = Coinsurance Payer C D3= Partial patient resource for Nursing home, ICF/MR and hospice services provided in a nursing home 80= Covered Days 81= Non Covered Days 82= Coinsurance Days 83= Lifetime Reserve Days 31=Nursing home, ICF/MR and hospice services provided in a nursing **Amounts must be valid amounts
42	R	Revenue Code	Enter the 4-digit revenue code. **CRITICAL ACCESS HOSPITALS:** **If there is an assigned CPT or HCPCS code for a drug billed with Revenue codes 025X and 0636, it must be billed along with the NDC information listed in Block 43 so drug rebates can be collected from drug companies.**

43	C	Description	When billing a CPT or HCPCS code for a drug, enter the NDC qualifier of N4, followed by the 11-digit NDC number, (space), and the unit of measurement followed by the metric decimal quantity or unit. • Do not enter a space between the qualifier and NDC. Do not enter hyphens or spaces within the NDC number. • **The NDC number being submitted to Medicaid must be the actual NDC number on the package or container from which the medication was administered.** Refer to the drug code list on the BMS website for a list of drugs that require NDC codes. Enter the NDC unit of measurement code and numeric quantity administered to the patient. Enter the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use a decimal point. The unit of measurement codes are as follows: F2 -International Unit GR-Gram ML-Milliliter UN- Unit Example N499999999999 ML22.4 Refer to www.dhhr.wv.org/bms.com for additional billing instructions / FAQ's.
Line 23	C	Page __ of __	Required if continuous bill; Page 1 of 3, page 2 of 3, etc.

44	C, RNH	HCPCS/Rates/HPPS code	Enter the appropriate CPT or HCPCS procedure code, followed by up to four 2 digit modifiers. Rates must be between 0 and 99999999 ($999,999.99). **For Nursing Homes:** Enter the appropriate HIPPS code AAA00-AAA29 if applicable (AAA +Case mix) If the provider is an **RHC/FQHC** and billing for **CPT 90853**, group therapy, the provider may only bill for a single patient, which will be pro-rated by WV Medicaid and dispersed over the total number of participants in the group session. Example: 1 patient billed for $50; group session includes 5 individual patient, pro-rates to $10 per patient Please use the form located at the bottom of these instructions to submit each claim.
45	RO, RNH	Service Date	Enter the line item service date (format MMDDCCYY). This field is used **only for outpatient** claims and Nursing Facilities. DOS must be within the last year, and prior to the receipt date. ***Note: Outpatient claims spanning June 30 thru July 1 and September 30 thru October 1 cannot be billed on the same claim*.**
46	R	Service Units	Enter the number of times the procedure billed was performed. Enter number of covered days **for inpatient only**. *Note: Outpatient surgery and recovery are to be billed in 15 minute time increments. Observation is to be billed in 1 hour units. See Attachment 1 of the Chapter 510 of the Provider Manual*, www.dhhr.wv.gov/bms.com
47	R	Total Charges	Enter Total Charges
48	C	Non-Covered Charges	Enter Non-Covered Charge.
49			No entry required.

50 A, B, C	C	Payer (A, B, C)	Enter the name identifying each payer organization from which the provider received payment for the bill. Enter "Medicaid" or "CHIP" for the State Medicaid payer identification. Enter the name of the third party payer if applicable using the following instructions: 50A for the primary payer, 50B for the secondary payer, and 50C for the tertiary payer. For Nursing Homes-ICF/MR's and hospice providers billing for nursing home services: Patient Resource is reflected in 50B.
51 A, B, C	C	Provider Number (A, B, C)	Enter 10 digit provider Medicaid ID if provider NPI is not available.
52		Release of Info Certification Indicator	No entry required.
53		Assignment of Benefits (Cert Indicator)	No entry required.
54A-C	C	Prior Payments (A, B, C)	Enter the amount(s) paid by each primary Carrier listed in field 50. Correspond the payment with the payers in field 50. Attach a copy of the EOB from the insurance or Medicare carrier. If claim or claim lines are denied, include the explanation of denial codes, if applicable, for claim processing. *Note: For Nursing Facilities-ICF/MRs* and hospice providers billing for nursing home services **only** *Enter the Patient Resource amount.*
55		Estimated Amount Due	No entry required.
56	R	NPI	Enter in the Provider NPI
58		Insured's Name	Enter insured's name if applicable. Last name, First name and Middle Initial.
59		Patient's Relation to Insured	No entry required.
60	R	Insured's Unique ID Number	Enter all of the insured's unique ID numbers assigned by each payer organization. The member's 11 (eleven) digit Medicaid ID number must be entered and correspond with the Medicaid entry in field 50 A, B, or C. If Medicaid is primary, enter the member's Medicaid ID in Field 60A. If Medicaid is secondary, enter the member's Medicaid ID in Field 60B. If Medicaid is tertiary, enter the member's Medicaid ID in Field 60C.
61	C	Group Name	Enter if applicable

62	C	Insurance Group Number	Enter if applicable
63	C	Treatment Authorization Codes	Enter the prior authorization number if applicable. Correspond each prior authorization number with the payer(s) listed in field 50 A, B, or C.
64	C	Document Control Number	Enter the original DCN (Claim ID Assigned by Medicaid or CHIP). This is the claim ID to be adjusted. **Required if the last digit of the claim frequency code is 7 or 8 in Block 4.
65		Employer Name	No entry required.
66	R	ICD Code Indicator	Enter 0 for ICD-10
67	R	Principal Diagnosis Code and POA Indicator (Required if in-patient)	Enter the ICD-10 code for the principal diagnosis in the unshaded area. Enter Present on Admission (POA) Indicator in the shaded area: Y=Yes N=No U=Documentation insufficient to determine W=Clinically undetermined
67 A-Q	C	Other Diagnosis Code and POA Indicator (Required if in-patient)	Enter the other ICD-10 Diagnosis Codes in the Unshaded code if applicable. Enter (Present on Admission) POA Indicator in the shaded area. See 67 above.
68			No entry required.
69	RI	Admitting Diagnosis Code	Enter the appropriate ICD-10 Admitting Diagnosis Code, if applicable.

70a-c	C	Patient Reason Code for Visit	Enter the appropriate ICD-9 or ICD-10 Reason Code, if applicable. Required for all unscheduled outpatient visits with a Type of Bill 013X or 085X with a type of admission 1, 2, or 5 and revenue codes of 045X, 0516, 0526 or 762.
71		PPS code	No entry required.
72	C	External Cause of Injury Code	Enter the ICD-10 External Cause of Injury code(s) if applicable
73			No entry required.
74	RI	Principle Procedure Codes	Enter the ICD-10 code and date (format MMDDCCYY) identifying the principal procedure for inpatient claims only.
74 A-E	C	Other Procedure Codes	Enter other procedure code(s) and date(s) (format MMDDCCYY) if applicable.
75			This field identifies the name and NPI of the individual with the primary responsibility for performing surgical procedures. Enter the Operating Physician's NPI, Last name and First name.
6	R	Attending NPI Qual Last Name First Name	Enter in the Attending Physicians NPI Last name and First name.
77	C	Operating	Required when surgical procedure is on the claim.

78/79	C	Other Providers	Use this field to report other providers involved with the patient's care. Enter the Provider's NPI, Last name and First name. A qualifier must be used to indicate the type of provider. Qualifiers are: ZZ Other operating physician DN Referring provider 82 Rendering provider
80		Remarks	No entry required.
81		Code/Code	No entry required.

Billing Instructions for Inpatient Hospital Claims when Member does not have Medicare PART A

Part A Benefits Exhausted

In situations where Part A benefits have been exhausted, the hospital must bill Medicare for the Part B ancillary charges and then bill Medicaid for the co-insurance and deductible.

The claim for these Part B services is submitted with Type of Bill 12x listing all of the ancillary services provided with CPT/HCPCS codes when applicable. If submitted on paper the claim must be accompanied by the Medicare EOMB.

Part A Benefits Exhausted During Inpatient Stay

In situations where the Part A benefits are exhausted during an inpatient stay, the hospital must bill Medicare for he Part A benefits that are covered and for the Part B ancillary charges after the Part A has exhausted. Because Medicare is primary at the time of admission, prior authorization is not required. The claim is submitted with Type of Bill 11x, listing charges for the entire stay, but showing the charges after Part A has been exhausted in the non-covered column. If submitted on paper, the claim must be accompanied by the Medicare EOMBs for both Part A and Part B charges.

No Part A Coverage

Some individuals are not eligible to receive Medicare Part A coverage. Medicaid will cover the Part A portion of inpatient stays for members with no Part A benefit. The claim submitted to Medicaid must include all charges for the stay, even the ancillary charges covered by Part B.

The claims for these services require special processing and must be submitted on paper, Type of Bill 11x, with the EOMB for the Part B Services attached. To be properly reimbursed the note “No Part A” must appear in block 84, the Remarks field. Payment for the admission will be based on the Medicaid allowed for the admission minus the Medicare Part B paid amount. If the claim is automatically crossed over by the Medicare intermediary, it will be necessary to Reverse and Replace that claim. Failure to do so will result in payment of only the Part B co-insurance and deductible.

No Part A Coverage on Date of Admission

Some individuals become eligible for Medicare Part A coverage during an admission. Medicaid will cover the portion of inpatient stay prior to the Part A coverage. The claim submitted to Medicaid must include all charges for the stay, even the charges covered by Part A.

The claims for these services require special processing and must be submitted on paper, Type of Bill 11x, with the EOMB for the Part A Services attached. To be properly reimbursed the note “No Part A on Admission” must appear in block 84, the Remarks field. Payment for the admission will be based on the Medicaid allowed for the admission minus the Medicare Part A paid amount. If the claim is automatically crossed over by the Medicare intermediary, it will be necessary to Reverse and Replace that claim. Failure to do so will result in payment of only the Part A co-insurance and deductible.)

RHC/FQHC claim submission form:

To be added when finalized