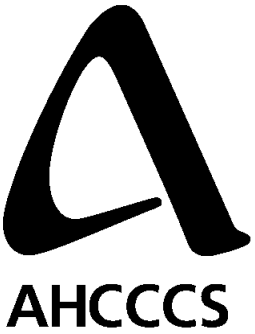
# Chapter 6

# Billing on the UB-04 Claim Form



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## INTRODUCTION

The UB-04 claim form is used to bill for all hospital inpatient, outpatient, and emergency room services. Dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services also are billed on the UB-04.

- ☑ Revenue codes are used to bill line-item services provided in a facility.
- ☑ Revenue codes must be valid for the service provided.
- ☑ Revenue codes also must be valid for the bill type on the claim.
  - ✓ For example, hospice revenue codes 651, 652, 655, 656 can only be billed on a UB-04 with a bill type 81X-82X (Special Facility Hospice).
  - ✓ If those revenue codes are billed with a regular inpatient bill type (11X – 12X), the claim will be denied.
- ☑ ICD-9 diagnosis codes are required.
  - ✓ AHCCCS does not accept DSM-4 diagnosis codes, and behavioral health services billed with DSM-4 diagnosis codes will be denied.
- ☑ ICD-9 procedure codes must be used to identify surgical procedures billed on the UB-04.
- ☑ CPT/HCPCS and modifiers must be used to identify other services rendered.

**NOTE:** This chapter applies to *paper* CMS 1500, UB-04, and ADA 2006 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.ahcccs.state.az.us. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

## COMPLETING THE UB-04 CLAIM FORM

The following instructions explain how to complete the UB-04 claim form and whether a field is "Required," "Required if applicable," or "Not required." The instructions should be used to supplement the information in the *AHA Uniform Billing Manual for the UB-04*.

**NOTE:** This chapter applies to paper UB-04 claims submitted to AHCCCS. For information on HIPAA-compliant 837 transactions, please consult the appropriate Implementation Guide. Companion documents for 837 transactions are available on the AHCCCS Web site at www.azahcccs.gov. The companion documents are intended to supplement, but not replace, the 837 Implementation Guides for the 837 transaction.

### 1. Provider Data — Required

Enter the name, address, and phone number of the provider rendering service.

**2. Unassigned** **Not required**

**3. Patient Control No.** **Required if applicable**

This is a number that the facility assigns to uniquely identify a claim in the facility's records. AHCCCS will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the AHCCCS Claim Reference Number (CRN) and the facility's accounting or tracking system.

**4. Bill Type** **Required**

Facility type (1st digit), bill classification (2nd digit), and frequency (3rd digit). See *UB-92 Manual* for codes.

| 2. | 3. PATIENT CONTROL NO. | 4. TYPE OF BILL |
|---|---|---|
| | | 111 |

**5. Fed Tax No.** **Required**

Enter the facility's federal tax identification number.

| 5. FED TAX NO. | 6. STATEMENT COVERS PERIOD FROM | THROUGH | 7. COVD |
|---|---|---|---|
| 86-1234567 | | | |

**6. Statement Covers Period** **Required**

Enter the beginning and ending dates of the billing period.

| 5. FED TAX NO. | 6. STATEMENT COVERS PERIOD FROM | THROUGH | 7. COVD |
|---|---|---|---|
| | 02/15/03 | 02/20/03 | |

**Or**

| | | | |
|---|---|---|---|
| | 02/15/2003 | 02/20/2003 | |

**8. Patient Name/Identifier** **Required**

Enter the recipient's last name, first name, and middle initial as they appear on the AHCCCS ID card.

**9. Patient Address** **Required**

**10. Patient Birth Date** **Required**

**11. Patient Sex** **Required**

**12. Admission/Start of care date** **Required**

| 12 ADMISSION/START OF CARE | 13 ADMISSION HOUR |
|---|---|
| | |

.

## 13. Admission hour — Required if applicable

## 14. Priority (type) of Admission/Visit — Required

Required for all claims. Enter the code that best describes the recipient's status for this billing period. An Admit Type of "1" is required for emergency inpatient and outpatient claims.

1 Emergency: Patient requires immediate medical intervention for severe, life threatening or potentially disabling conditions. Documentation must be attached to claim.

2 Urgent: Patient requires immediate attention. Claim marked as urgent will not qualify for emergency service consideration.

3 Elective: Patient's condition permits time to schedule services.

4 Newborn: Patient is newborn. Newborn source of admission code must be entered in Field 20.

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.

## 15. Point of Origin for Admission or Visit — Required

## 16. Discharge Hour — Required if applicable

Enter the code which best indicates the recipient's time of discharge. Required for inpatient claims when the recipient has been discharged. See *UB-04 Manual* for code structure.

## 17. Patient discharge status — Required

Required for all claims. Enter the code that best describes the recipient's status for this billing period

01 Discharged to home or self-care (routine discharge)

02 Discharged/Transferred to a short-term general hospital for inpatient care

03 Discharge/Transferred to SNF with Medicare Certification in anticipation of skilled care

04 Discharge/Transferred to a facility that provides custodial or supportive care

05 Discharge/Transferred to a designated cancer center or children's hospital

06 Discharge/Transferred to home under care an organized home health service organization in anticipation of covered skilled care

07 Left against medical advice or discontinued care

09 Admitted as an inpatient to this hospital

20 Expired

21 Discharged/Transferred to Court/Law Enforcement

30 Still a patient

40 Expired at home

41 Expired in a medical facility (e.g., hospital, SNF, or ICF or free-standing hospice

42 Expired, place unknown (hospice only)

43 Discharged/Transferred to a federal health care facility

50 Discharged to Hospice - home

51 Discharged to Hospice - medical facility (certified) providing hospice level of care

61 Discharge/Transferred within this institution to a hospital-based Medicare-approved swing bed

62 Discharge/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital

63 Discharge/Transferred to a Medicare-certified long term care hospital (LTCH)

64 Discharge/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 hospital

66 Discharges/Transfers to a Critical Access Hospital

70 Discharged/Transferred to another type of healthcare institution not defined elsewhere in this code list

**18-28 Condition Codes** **Required if applicable**

Enter the appropriate condition codes that apply to this bill. See *UB-04 Manual* for codes.

In-state, non-IHS inpatient hospitals may request outlier consideration for a claim by entering "61" in any Condition Code field.

To bill for self-dialysis training, free-standing dialysis facilities approved to provide self-dialysis training must enter "73" in any Condition Code field and bill revenue code 841 (Continuous Ambulatory Peritoneal Dialysis, per day) or revenue code 851 (Continuous Cycling Peritoneal Dialysis, per day).

To bill for multiple distinct/independent outpatient visits on the same day facilities must enter "GO".

**29. Accident State** **Required if applicable**

**31-34 Occurrence Codes and Dates** **Required if applicable**

**35-36. Occurrence Span codes and dates** **Required if applicable**

**38. Responsible Party Name and Address** **Required if applicable**

**39-41 Value Codes and Amounts** **Required if applicable**

**42. Revenue Code** **Required**

Enter the appropriate revenue code(s) that describe the service(s) provided. See *UB-04 Manual* for revenue codes and abbreviations. Revenue codes should be billed chronologically for accommodation days and in ascending order for non-accommodation revenue codes. Accommodation days should not be billed on outpatient bill types.

| | 42. REV. CD. | 43. DESCRIPTION | 44. HCPCS/RATES |
|---|---|---|---|
| 1 | 132 | | |
| 2 | 251 | | |
| 3 | 258 | | |
| 4 | | | |

**43. Revenue Code Description/NDC code (effective 7/1/12) Required/NDC if applicable**

Enter the description of the revenue code billed in Field 42. See *UB-04 Manual* for description of revenue codes.

| | 42. REV. CD. | 43. DESCRIPTION | 44. HCPCS/RATES |
|---|---|---|---|
| 1 | | OB/3&4 BED | |
| 2 | | DRUGS/GENERIC | |
| 3 | | IV SOLUTIONS | |
| 4 | | | |

To report the NDC on the UB04 claim form, enter the following information into the Form Locator 43 (Revenue Code Description):

- The NDC Qualifier of N4 in the first 2 positions on the left side of the field.
- The NDC 11-digit numeric code, without hyphens.
- The NDC Unit of Measurement Qualifier (as listed above)
- The NDC quantity, administered amount, with up to three decimal places (i.e., 1234.456). Any unused spaces are left blank.

The information in the Revenue Description field is 24 characters in length and is entered without delimiters, such as commas or hyphens.

| | 42. REV. CD. | 43. DESCRIPTION | 44. HCPCS/RATES | 46. SERV. UNITS |
|---|---|---|---|---|
| 1 | 0250 | N400074115278 ML10 | J1642 | 2.00 |
| 2 | | | | |
| 3 | | | | |

**44. HCPCS/Rates Required if applicable**

Enter the inpatient (hospital or nursing facility) accommodation rate. Dialysis facilities must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes (See Chapter 15, Dialysis Services). Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services (See Chapter 11, Hospital Services).

| | 42. REV. CD. | 43. DESCRIPTION | 44. HCPCS/RATES |
|---|---|---|---|
| 1 | | | 1,088.00 |
| 2 | | | 85595 |
| 3 | | | 95900 |
| 4 | | | |

- Form Locator 44 (HCPCS/Rate/HIPPS code): Enter the corresponding HCPCS code associated with the NDC.

| | 42. REV. CD. | 43. DESCRIPTION | 44. HCPCS/RATES | 46. SERV. UNITS |
|---|---|---|---|---|
| 1 | 0250 | N400074115278 ML10 | J1642 | 2.00 |
| 2 | | | | |
| 3 | | | | |

**45. Service Date** **Required**

The dates indicated outpatient service was provided on a series bill. The date of service should only be reported if the From and Through dates in Form Locator 6 are not each other on the form. Enter the date in MM/DD/YY or MM/DD/YYYY format.

**46. Service Units** **Required**

Number of units for ALL services must be indicated.
If accommodation days are billed, the number of units billed must be consistent with the patient status field (Field 22) and statement covers period (Field 6). If the recipient has been discharged, AHCCCS covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the recipient expired or has not been discharged, AHCCCS covers the admission date through last date billed.

| 46. SERV. UNITS | 47. TOTAL CHARGES | 48. NON-COVERED CHARGES | 49. |
|---|---|---|---|
| 2.00 | | | |
| 3.00 | | | |
| 30.00 | | | |
| | | | |

- Form Locator 46 (Serv Units/HCPCS Units): Enter the number of HCPCS units administered.

| | 42. REV. CD. | 43. DESCRIPTION | 44. HCPCS/RATES | 46. SERV. UNITS |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| 1 | 0250 | N400074115278 ML10 | J1642 | 2.00 |
| 2 | | | | |
| 3 | | | | |

## 47. Total Charges — Required

Total charges are obtained by multiplying the units of service by the unit charge for each service. Each line other than the sum of all charges may include charges up to $999,999.99. Total charges are represented by revenue code 001 and must be the last entry in Field 47. Total charges on one claim cannot exceed $999,999,999.99.

| 46. SERV. UNITS | 47. TOTAL CHARGES | | 48. NON-COVERED CHARGES | | 49. |
|---|---|---|---|---|---|
| | 2,176 | 00 | | | |
| | 104 | 26 | | | |
| | 529 | 92 | | | |
| | | | | | |

## 48. Non-covered Charges — Required if applicable

Enter any charges that are not payable by AHCCCS. The last entry is total non-covered charges, represented by revenue code 001. Do not subtract this amount from total charges.

## 50. (A–C) Payer — Required

Enter the name and identification number, if available, of each payer who may have full or partial responsibility for the charges incurred by the recipient and from which the provider might expect some reimbursement. If there are payers other than AHCCCS, AHCCCS should be the last entry. If there are no payers other than AHCCCS, AHCCCS will be the only entry.

| | 50. PAYER | 51. PROVIDER NO. | 52. REL INFO | | 53. ASG BEN |
|---|---|---|---|---|---|
| A | AHCCCS | | | | |
| B | | | | | |
| C | | | | | |

## 51. (A–C) Healthplan Identification No. — Required

Enter the facility's ID number as assigned by the payer(s) listed in Fields 50 A, B, and/or C. The facility's six-digit *AHCCCS service provider ID number* should be listed last. Behavioral health providers must not enter their BHS provider ID number.

| 50. PAYER | 51. PROVIDER NO. | 52. REL INFO | | 53. ASG BEN |
|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| A | | 654321 | | | |
| B | | | | | |
| C | | | | | |

**52.**
**(A–C) Release of Information** **Not required**

**53.**
**(A–C) Assignment of Benefits** **Not required**

**54.**
**(A–C) Prior Payments** **Required if applicable**

Enter the amount received from Medicare Part B (Inpatient Only) or any other insurance or payer *other than AHCCCS*, including the patient, listed in Field 50. If the recipient has other insurance but no payment was received, enter "Ø." The " Ø " indicates that a reasonable attempt was made to determine available coverage and obtain payment. Enter only actual payments received. Do not enter any amounts expected from AHCCCS.

**55.**
**(A–C) Amount due** **Not required**

**56. National Provider Identifier-Billing Provider** **Required**

**57. Other (Billing) Provider Identifier** **Required if applicable**

**58.**
**(A–C) Insured's Name** **Not Required**

Enter the name of insured (AHCCCS recipient) covered by the payer(s) in Field 50.

| | 58. INSURED'S NAME | 59. P.REL. | 60. CERT. – SSN - HIC. - ID NO. |
|---|---|---|---|
| A | Holliday, John H. | | |
| B | | | |
| C | | | |

**59.**
**(A–C) Patient's Relationship To Insured** **Not required**

**60.**
**(A–C) Patient CERT. - SSN – HIC – ID NO.** **Not required**

Enter the recipient's AHCCCS ID number. If there are questions about eligibility or the AHCCCS ID number, contact the AHCCCS Verification Unit. (See Chapter 2, Recipient Eligibility and Enrollment). Behavioral health providers must be sure to enter the client's AHCCCS ID number, not the client's BHS number.

| | 58. INSURED'S NAME | 59. P.REL. | 60. CERT. –SSN - HIC. - ID NO. |
|---|---|---|---|
| A | | | A12345678 |
| B | | | |
| C | | | |

**61.**
**(A–C) Group Name** **Not required**

Enter "FFS" for AHCCCS IHS and ESP recipients.

| 60. CERT. –SSN - HIC. - ID NO. | 61. GROUP NAME | 62. INSURANCE GROUP NO. |
|---|---|---|
| | FFS | |
| | | |
| | | |

**62.**
**(A–C) Insurance Group Number** **Not required**

**63.**
**(A–C) Treatment Authorization** **Not required**

The AHCCCS claims system automatically searches for the appropriate authorization for services that require authorization. See Chapter 8, Authorizations, for information on prior authorization.

**64. Document Control Number** **Not required**

**65.**
**(A–C) Employer Name** **Not required**

**66. Diagnosis and Procedure Code Qualifier** **Required**

**67. Principal Diagnosis Code** **Required**

Enter the principal *ICD-9 diagnosis code*. Behavioral health providers must **not** use DSM-4 diagnosis codes.

| 66. PRIN. DIAG CODE | OTHER DIAG. CODES | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 68. CODE | 69. CODE | 70. CODE | 71. CODE | 72. CODE | 73. CODE | 74. CODE | 75. CODE |
| 585.0 | | | | | | | | |

**69. Admitting Diagnosis** **Required**

Required for inpatient bills. Enter the ICD-9 diagnosis code that represents the significant reason for admission.

**70. Patient's Reason for Visit** **Not required**

**72 E-Codes** **Required if applicable**

Enter trauma diagnosis code, if applicable.

**74. Principal Procedure Code and Dates** **Required if applicable**

Enter the principal ICD-9 procedure code and the date the procedure was performed during the inpatient stay or outpatient visit. Enter the date in MM/DD/YY or MM/DD/YYYY format. If more than one procedure is performed, the principal procedure should be the one that is related to the primary diagnosis, performed for definitive treatment of that condition, and which requires the highest skill level.

**76. Attending Provider name and identifiers** **Required if applicable**

**77. Operating Physician Name and Identifiers** **required if applicable**

**78-79. Other Physician** **Not required**

**80. Remarks** **Required if applicable**

Required on resubmissions, adjustments, and voids. Enter the CRN of the claim being resubmitted, adjusted, or voided. For resubmissions of denied claims, write "Resubmission" in this field.

**81. Other Procedure Codes** **Required if applicable**

Enter other procedure codes in descending order of importance.

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