Medicare Essentials Part 2: "Completing the UB-04 Claim Form"

Presented by Provider Outreach and Education

January 14, 2014

Disclaimer

This resource is not a legal document. This presentation was prepared as a tool to assist our providers.

This presentation was current at the time it was created. Although every reasonable effort has been made to assure accurate information, responsibility for correct claims submission lies with the provider of services.

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Overview

- Claims are submitted either electronically or by paper
- Institutional providers bill for services based on the CMS-1450 also known as the UB-04
- UB-04 has 81 Form Locators (FL)
- Claim size 450 Lines

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UB-04/CMS1450

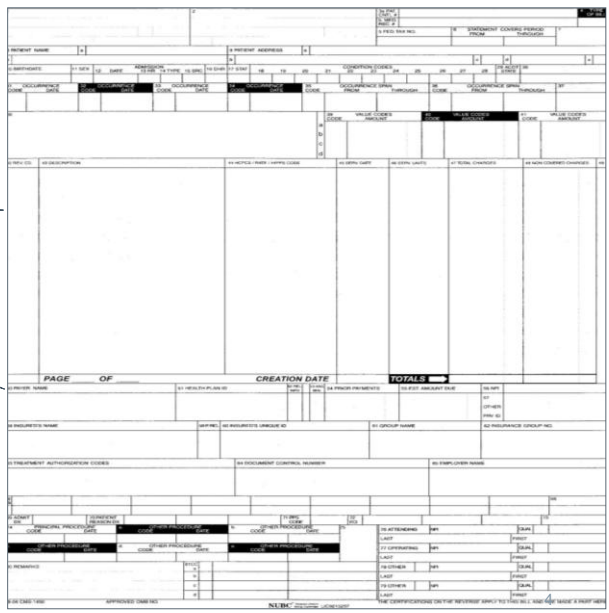
Patient/Provider Information

Billing Information

Payer Information

Diagnostic Information

Additional Information



Patient/Provider Information

Form Locator 1– Billing Provider Name, Address and Telephone number – Required

- Enter the billing provider's name, address and telephone number
- Information is used in connection with Medicare provider number to verify provider identity

1 Happy Hospital			
999 Happy Lane			
Birmingham		AL	33333-3333

5

Patient/Provider Information

Form Locator 3a – Patient Control Number Required

- Enter the patient's control number assigned by the provider to allow retrieval of patient financial records

3a PAT. CNTL #	B123456701

6

Patient/Provider Information

Form Locator 4 – Type of Bill - Required

- Used on inpatient and outpatient claims for the purpose of third party claim processing
- CMS ignores the leading zero
- Fourth digit referred to as a “frequency code”

4 TYPE OF BILL
0111

7

Patient/Provider Information

- **Form Locator 5 - Federal Tax ID – Required**
- Enter in format NN-NNNNNNN
- **Form Locator 6 - Statement Covers Period – Required**
- Enter dates of service on the bill in numeric fields

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH
12-3456789	01 01 12	01 10 12

8

Patient/Provider Information

Form Locator 8a – 8b Patient Name/ID Required

- Enter the patient's ID in 8a if different than the subscriber/insured's ID
- Enter the patient's name in the following format:
  - Last name, first name, and, middle initial, if any
- Patient's name should be entered as shown on Medicare card

8 PATIENT NAME	a	Enter if different than subscriber/insured ID
b	Doe, Daffy, D	

9

Patient/Provider Information

Form Locator 9a – 9e Patient's Address Required

- Enter the patient's complete mailing address

9 PATIENT ADDRESS	a	1234 Cahaba Lane					
b	Birmingham		c	AL	d	33333	e

Form Locator 10 – Patient's DOB – Required

- Enter DOB using the MMDDCCYY format

Form Locator 11 – Patient's Sex – Required

- Enter patient sex recorded at time of registration

10 BIRTHDATE	11 SEX
03 15 1942	F

10

Patient/Provider Information

Form Locator 12 – Admission Date – Required

- Required for Inpatient claims
- Enter date patient was admitted to facility (MMDDYY)

Form Locator 14 – Priority Type of Admission Required

- Required on Inpatient bills only

Form Locator 15 – Point of Origin for Admission – Required

- Indicates source of referral for the admission or visit

	ADMISSION			
12 DATE		13 HR	14 TYPE	15 SRC
01 01 2012			3	1

11

Patient/Provider Information

Form Locator 17 – Pt. Discharge Status – Required

- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred
- 20 Expired

17 Stat
01

12

Patient/Provider Information

Form Locator 35 – 36 - Occurrence Span code and Dates – Required

- Required for Inpatient
- Enter beginning and ending dates of the specific event relating to the bill

35 CODE	OCCURRENCE SPAN FROM	THROUGH	36 CODE	OCCURRENCE SPAN FROM	THROUGH
70	01 01 12	01 10 12			

13

Patient/Provider Information

Form Locator 39 - 41- Value Codes and Amounts - Required

- Codes are used to identify data of a monetary nature that is necessary to process the claim
- Two alpha numeric digit codes
- Value codes 80-83 are only available for use on the UB-04

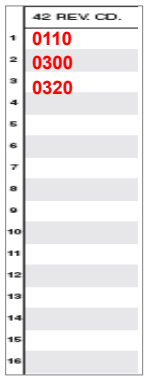
	39 CODE	VALUE CODES AMOUNT		40 CODE	VALUE CODES AMOUNT		41 CODE	VALUE CODES AMOUNT
a	A1	1,024	00					
b								
c								
d								

14

Billing Information

Form Locator 42 – Revenue Code - Required

- Enter the appropriate revenue code for services rendered
- Provider can enter up to 22 revenue codes
- Revenue code should explain charge in Form Locator 47



	42 REV. CD.
1	0110
2	0300
3	0320
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	

15

Billing Information

Form Locator 44 – HCPCS/RATE/HIPPS Code – Required

- Provider enters the HCPCS code describing the procedure for outpatient service
- Accommodation rate is entered for inpatient hospital bills

44 HCPCS/Rate/HPPS/ Code
520.00

16

Billing Information

Form Locator 45 – Service Date – Required

- Required on outpatient claims
- Indicates date outpatient services were provided
- Enter date using six-digit format (MMDDYY)

45 Service Date
Required on Outpatient Claims

17

Billing Information

Form Locator 46 – Units of Service – Required

- Number of days and pints of blood are reported
- Provider enters up to seven numeric digits

Form Locator 47 – Total Charges – Required

- Enter total charges related to the billing period
- Allows up to nine numeric digits (0000000.00)

Form Locator 48 – Non-covered Charges – Required

- Enter non-covered charges as related to the revenue code in form locator 42

46 Serv. Units	47 Total Charges	48 Non-cov. charges
9	4680 00	0 00
8	830 00	0 00
1	252 00	0 00

18

Billing Information

Total Charges

- Enter the total amount billed
- Add the charges that are listed in column 47
- Do not use dashes
- Each claim form is a separate document and should be totaled separately

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Payer Information

Form Locator 50a, b, c – Payer Identification – Required

- Enter the name of primary, secondary and tertiary payer
- If Medicare is primary, enter it on line “A”
- Multiple payers should be listed in priority sequence

Form Locator 51a, b, c – Health Plan ID – Required

- Enter ID number of the patient’s health insurance plan responsible for payment

50 Payer Name	51 Health Plan ID
Primary Payer Secondary Payer Tertiary Payer	Enter the national health plan id in this field

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Payer Information

Form Locator 52a, b, c – Release of Information – Required

- "Y" indicates the provider has on file a signed statement from the member to release information
- "I" indicates informed consent to release medical information for conditions or diagnoses regulated by federal statutes

52 Rel. Info
Y

21

Payer Information

Form Locator 56 – Billing Provider NPI – Required

- Report National Provider Identifier assigned to provider Required as of May 23, 2008
- Visit https://nppes.cms.hhs.gov/NPPES/Welcome.do to register for an NPI

56 NPI	3333555111

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Payer Information

Form Locator 58a, b, c – Insured's Name Required

- Name of the individual who carries the insurance

58 Insured's Name
Doe, Daffy D
Doe, Duckie D

23

Payer Information

Form Locator 59 – Patient Relationship to Insured – Required

- Enter the code indicating relations of patient to the identified insured

59 P. Rel
18
01

24

Payer Information

Form Locator 60 –Insured Unique ID - Required

- Enter number assigned by health plan to the insured
- Enter number exactly as it appears on patient's ID card

60 Insured's Unique ID
987656781A
123459780

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Diagnostic Information

Form Locator 66 – Diagnosis and Procedure Code Qualifier – Required

- Qualifier that denotes the version of ICD reported
- ICD: 9 - Ninth Revision, 0 - Tenth Revision

66 DX
9

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Diagnostic Information

Form Locator 67– Principal Diagnosis Codes Required

- Code is chiefly responsible for the admission
- Principal diagnosis will include the use of "V" codes
- Report full ICD diagnosis code, including all five digits

Form Locator 67A – 67Q – Other Diagnosis Codes Required

- Used to identify codes in addition to the chief diagnosis code that coexist, develop after admission or impact the treatment of the patient or the length of stay
- Enter up to eight additional conditions or diagnoses

59010	Report "other diagnosis" in box A - Q						

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Diagnostic Information

Form Locator 69– Admitting Diagnosis Required

- Applies to inpatient claims subject to QIO review
- Enter a valid ICD-9-CM diagnosis code that describes the diagnosis of the patient at the time of admission

69 Admit DX	59010

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UB-04 Common Errors

- Health Insurance Claim Number not present on the claim or invalid HIC
- Invalid National Provider Identifier (NPI) number
- Medicare not listed as a payer
- Revenue codes not listed on claim

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Paper Claim Exceptions

- Small provider claims;
- Participation in a demonstration project requiring paper submission;
- Paper roster billing;
- More than one primary payer;
- Services furnished outside of United States;
- Dental claims;
- Claims submitted by Medicare beneficiaries or Medicare Managed Care Plans

For additional information, visit

CMS IOM, Publication 100-04, Chapter 24 Sections 90-90.6

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Advantages of Electronic Claim Submission

- Electronic Media Claims (EMC)
  - Improves timeliness
  - Cost effective
  - Eliminate claim submission errors
  - Correct and resubmit
  - Confirmation of receipt
  - Faster payment

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Electronic Data Interchange

Fiscal Intermediary Standard System (FISS)

Direct Data Entry (DDE)

- Enter and submit claims
- Correct and resubmit Return to Provider (RTP) Claims
- Inquire about patient eligibility
- Access revenue, HCPCS and ICD-9-codes

File Transfer

- Submit claims through third-party software
  - Vendor
  - Billing service or clearinghouse
  - Free PC-Ace Pro32™

www.cahabagba.com/part-a/claims/electronic-data-interchange-edi/

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Direct Data Entry (DDE)

- Annual recertification now required for DDE users
  - All users whose credentials were established before December 1, 2013
- Recertification must be complete by February 28, 2014
- Recertifying or deleting your user IDs with Cahaba will have no impact on that user ID for any of the other MACs where it is in use
- Form available at:

  www.cahabagba.com/part-a/claims/electronic-data-interchange-edi/forms/

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ICD-10

- Deadline to transition to ICD-10 is October 1, 2014
- Basics
- Implementation Guides
- Timelines

  www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

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ICD-10 Training Webinar Video

Video is now available on the ICD-10 Provider Resources web page

http://cms.gov/Medicare/Coding/ICD10/ProviderResources.html

Webinar includes information on:

- Changes in code structure, code definitions, and recurring patterns that help providers to understand the organization and content of ICD-10 codes
- The importance of clinical documentation
- Approaches to assess ICD-10 readiness, identify gaps, prioritize tasks, and monitor progress through continuous quality improvement

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ICD-10 Testing

ICD-10 testing week: March 3-7, 2014

Registration required

What to expect:

- Test claims must be submitted with current dates of service (i.e. October 1, 2013 through March 3, 2014)
- Test claims will receive the 277CA or 999 acknowledgement to confirm the claim was accepted or rejected in the system
- Testing will not confirm claim payment or produce remit
- MACs and CEDI will be staffed to handle call volume

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Resources

- Medicare Claims Processing Manual 100-04, Chapter 25

  www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c25.pdf
- CMS Web Based Training

  www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html
- National Uniform Billing Committee (NUBC)

  www.nubc.org/
- FISS Reference Guide

  www.cahabagba.com/part-a/education/educational-materials/

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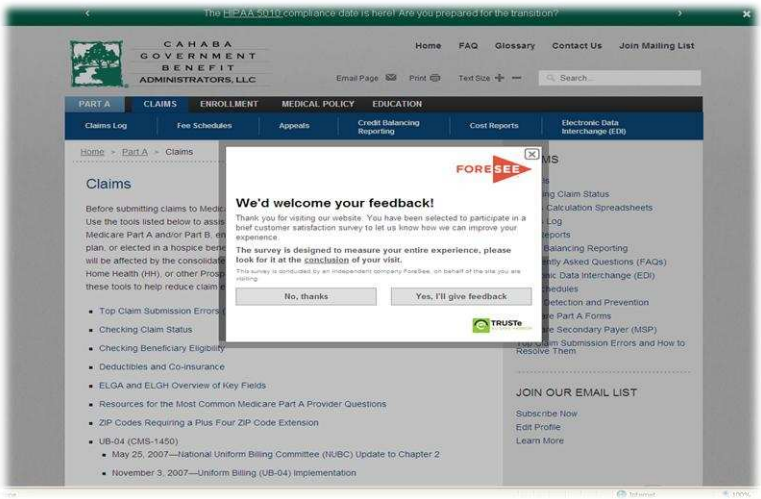
ForeSee



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Thank You!

Please complete the electronic evaluation upon exiting the webinar

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