Department of Health and Mental Hygiene

Maryland Medical Assistance Program

Uniform Billing (UB04)

Nursing Facility Billing Instructions

Effective January 1, 2015

Updated December 2014

Contents

Completion of UB04 for Nursing Facility Services

Introduction

The uniform bill for institutional providers is known as the UB04. The UB04 is suitable for use in billing multiple third party liability (TPL) payers. When submitting claims, complete all items required by each payer who is to receive a copy of the form. These billing instructions use "Form Locators" to detail only those data elements required for Medical Assistance 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://dhmh.maryland.gov/hipaa/sitepages/transandcodesets.aspx

The basis for all payments is COMAR 10.09.10 and the Nursing Facility Reimbursement Manual.

Please see the Eligibility Verification System (EVS) section in this manual regarding participant Medicaid eligibility prior to billing.

Billing Time Limitations

Invoices must be received within twelve (12) months of the month of service on the invoice. If a claim is received but rejected within the 12-month limit, resubmission will be accepted within 60 days of the date of rejection or within 12 months of the month of service, whichever is longer. If a claim is rejected because of late receipt, the resident 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.

Medicare Part A Coinsurance

For participants in both Medicare Part A and Medicaid, Medicaid pays coinsurance claims for days 21-100 of a nursing facility stay. This payment is the difference between the Medicare Part A rate and the Medicaid Statewide average.

The specific procedure for billing Part A Coinsurance Days is as follows:

1. For days of care that include Part A Coinsurance Days, bill Medicare. You will receive payment from Medicare and an Explanation of Benefits (EOB).
2. For days where Medicare's payment for coinsurance days is equal to or greater than the statewide average Medicaid payment, the provider bills revenue code 0101 electronically for coinsurance days at the coinsurance per diem rate established by CMS. The Program will pay $0.00 for these days. The provider will have documentation of $0.00 payment and a

remittance advice that states, “Payment for Medicare Part A Coinsurance Days is limited to Maryland Medicaid’s obligation.

3. For days where Medicare’s payment is less than the statewide average Medicaid payment, Medicaid will owe some amount. The provider bills the Program by paper on the UB04 for coinsurance days at the coinsurance per diem rate established by CMS. The provider attaches the “Coinsurance Worksheet” and a copy of the Medicare EOB. The Program will allow the amount calculated on the “Coinsurance Worksheet.” The provider will have documentation of a reduced payment and a remittance advice that states, “Payment for Medicare Part A Coinsurance Days is limited to Maryland Medicaid’s obligation.”
4. Regarding Patient Resource. Maryland Medicaid’s monthly obligation, for example, $1,000, is offset by any existing patient resource. If $200 is available from the patient resource, Medicaid would allow the $1,000 and pay $800. The patient resource is applied as part of Maryland Medicaid’s obligation, not in addition to that obligation. If in the above example the available resource was $1,200, Medicaid would pay $0.00 and the provider would collect only $1,000 of the available $1,200 resource. The provider may collect patient resource amounts only up to the difference between Medicaid’s obligation (as calculated on the Coinsurance Worksheet) and Medicaid’s payment. The provider may not collect patient resource in excess of the Medicaid obligation.

Please see the Coinsurance Worksheet at the website below on payments for this revenue code. This worksheet also instructs providers whether to bill electronically or by paper.

Note that per diems established by CMS and the State of Maryland change throughout the year (usually on January 1 and July 1).

https://mmcp.dhmh.maryland.gov/longtermcare/SitePages/Nursing%20Home%20Services.aspx

Paper Invoices

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.

Mail completed invoices to the following address:

Maryland Medical Assistance Program
Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203

Adjustments

Adjustments should be completed when a specific bill has been issued for a specific provider, resident, 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

Eligibility Verification System (EVS)

In order to bill for a Medicaid participant, they must have an active Medicaid span. This information is available to providers through an Eligibility Verification System, or EVS.

It is the provider's responsibility to check eligibility prior to rendering services.

What is EVS?

EVS is a telephone-inquiry system that enables health care providers to quickly and efficiently verify a Medicaid recipient's current eligibility status. It will tell you if the recipient is enrolled with a Managed Care Organization (MCO) or if they have third party insurance.

Before providing services, you should request the recipient's Medical Care Program identification card. If the recipient does not have the card, you should request a Social Security number, which may be used to verify eligibility.

EVS also allows a provider to verify past dates of eligibility for services rendered up to one year ago. If the Medical Assistance identification number is not available, you may search current eligibility and past eligibility up to one year by using a recipient's Social Security Number and name code.

EVS is an invaluable tool to Medicaid providers for ensuring accurate and timely eligibility information for claim submissions. If you need additional information, please call the Provider Relations Unit at 410-767-5503 or 1-800-445-1159.

For more information on how to use the EVS system, please go to:

https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx

Web EVS

For providers enrolled in eMedicaid, Web EVS, a web-based eligibility application is now available at https://encrypt.emdhealthchoice.org/. Providers must enroll in eMedicaid in order to access Web EVS. If you need information or application support, please visit the website or call 410-767-5340.

Sample UB04


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
CONDITION CODES
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
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL INFO
53 ASG BEN
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
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
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
APPROVED OMB NO.
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.
NUBC
LIC9213257

UB04 Form Locators (FL)

The instructions that follow correspond to the form locator number and headings on the UB04 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 return street address 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 (Not required).

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 Resident Control Number

Required. Enter the resident's unique alphanumeric control number assigned to the resident by the facility. A maximum of 20 positions will be returned on the remittance advice to the provider.

FL 03b Medical/Health Record Number

Not required. Enter the medical/health record number assigned to the resident by the facility when the provider needs to identify for future inquiries, the actual medical record of the resident. 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, or "frequency" code, indicates the bill sequence for this particular episode of care. 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 gray can be used for Maryland Medicaid Nursing Facility claims.[1]

[1] 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.

Type of Bill (Do NOT report leading zero)	Description	Inresident/Outresident General Designation
021x	Skilled Nursing – Inresident (Including Medicare Part A)	IP
Type of Bill Frequency Codes:		
1	Admit Through Discharge Claims	The provider uses this code for a bill encompassing an entire inresident 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)	This code is to be used when a specific bill has been issued for a specific provider, resident, 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)	This code reflects the elimination in its entirety of a previously submitted bill for a specific provider, resident, 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.

FL 05 Federal Tax Number

Not required.

FL 06 Statement Covers Period (From - Through)

Required. Enter the "From" and "Through" dates covered by the services on the invoice (MMDDYY). The "Through" date equals the date through which we are paying for services. Remember that Medical Assistance does not pay for services for the date of death/discharge. The date of death/discharge should never be shown as the through date in this field. Medicare Part A and Part B claims should include the "From" and "Through" dates as indicated on the Medicare payment listing or EOMB.

FL 07 Reserved for Assignment by NUBC – NOT USED

FL 08a Resident Name – Identifier

Not Required.

FL 08b Resident Name

Required. Enter the resident'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 Resident Address

Not Required.

FL 10 Resident Birth Date

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

FL 11 Resident Sex

Not required.

FL 12 Admission/Start of Care Date

Required. Enter the start date for this episode of care. For nursing home services, this is the date of admission. Enter the Admission/Start of Care Date as (MMDDYY).

FL 13 Admission Hour

Not required.

FL 14 Priority (Type) of Visit

Required. Enter the code indicating priority of this admission.

Code Structure – Priority (Type of Visit)		
1	Emergency	The resident requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the resident is admitted from an emergency room.
2	Urgent	The resident requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the resident is admitted to the first available and suitable accommodation.
3	Elective	The resident's condition permits adequate time to schedule the availability of a suitable accommodation.

FL 15 Source of Referral for Admission or Visit

Required. Enter the code indicating the source of the referral for this admission or visit.

Code Structure: Source of Referral for Admission or Visit		
1	Physician Referral	The resident was admitted to this facility upon the recommendation of his or her personal physician.
2	Clinic Referral	The resident was admitted to this facility upon recommendation of a clinic's physician.
3	HMO Referral	The resident was admitted to this facility upon the recommendation of a health maintenance organization physician.
4	Transfer from a Hospital	Transfer from a hospital
5	Transfer from a Skilled Nursing Facility	The resident 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	The resident 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 residents that are at a non-skilled level of care.
8	Court/Law Enforcement	The resident 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)	The means by which the resident was admitted to this nursing facility is not known.

FL 16 Discharge Hour

Not Required.

FL 17 Resident Discharge Status

Required. A code indicating the disposition or discharge status of the resident at the end of service for the period covered on this bill, as reported in FL6, Statement Covers Period.

Enter code from code structure below indicating the resident's disposition at the time of billing for that period of inresident care.

Code Structure: Resident Discharge Status	
01	Discharged to self or home care (routine discharge) Usage Notes: Includes discharge to home; jail or law enforcement; home on oxygen if DME only; any other DME only; group home, foster care, and other residential care arrangements; outresident programs, such as partial hospitalization or outresident chemical dependency programs; assisted living facilities that are not state-designated.
02	Discharged/transferred to another short-term general hospital for inresident care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care.
04	Discharged/transferred to an intermediate care facility (ICF) Usage Notes: Typically defined at the state level for specifically designated intermediate care facilities. Also used to designate residents that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to state designated Assisted Living Facilities.
05	Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List. Usage Notes: Designated cancer hospitals excluded from Medicare PPS and children's hospitals are examples of such facilities. **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 in anticipation of covered skilled care. Usage Notes: Report this code when the resident is discharged/transferred to home with a written plan of care for home care services. Not used for home health services provided by a DME supplier or from a Home IV provider for home IV services.

Code Structure: Resident Discharge Status	
07	Left against medical advice or discontinued care
20	Expired
30	Still a resident
43	Discharge/Transferred to a Federal Healthcare Facility Usage Notes: Discharges and transfers to a government operated health facility such as a Department of Defense hospital, a Veteran's Administration hospital or a Veteran's Administration's nursing 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 Inresident 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	Effective 10/1/07: **NOT USED** 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 the code and associated date defining a significant event relating to this bill that may affect payer processing. Enter all dates as MMDDYY.

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: 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 Value Codes, including those reported in FL 81.

Enter the appropriate codes and dates from the table below.

Code Structure – Occurrence Codes & Dates:		
24	Date Insurance Denied	Code indicating the date the denial of coverage was received by the facility 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 resident.
42	Date of Discharge	Use only when "Through" date in FL 6 (Statement Covers Period) is <u>not</u> the actual discharge date <u>and</u> the frequency code in FL 4 is that of a final bill.

FL 35-36 a-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:		
70	Qualifying Stay Dates For SNF Use ONLY	The from/through date of at least a 3-day inresident hospital stay that qualifies the resident for Medicare payment of SNF services billed. Code can be used only by SNF for billing.
71	Prior Stay Dates	The from/through dates given by the resident of any hospital stay that ended within 60 days of this hospital or SNF admission.
75	Administrative Day Dates	Administrative Day Code and Span. These days must be billed under the Administrative Day revenue code, 0169, in FL42
78	SNF Prior Stay Dates	The from/through dates given by the resident of any SNF or nursing home stay that ended within 60 days of this hospital or SNF admission.

Note: Code 75 must be used when billing for Administrative Days. Therefore, in FL35 enter Code 75 and the span dates covered under FROM and THROUGH. These days must be reported under the Administrative Day Revenue Code, 0169, in FL42.

Administrative Day span data will be given to the Program's Utilization Control Agent (UCA) along with the other data they receive from the monthly claim. The UCA will check to see if documentation for Administrative Days exists for the days entered on the claim. If the documentation for Administrative Days does not exist or is not acceptable, the days will be adjusted.

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.

Enter Value Codes in alphanumeric sequence. 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[2]	Covered days	The number of days covered by the primary payer as qualified by the payer.

Note: Code 80 replaces UB form locator for covered days. This value code must be entered, showing the number of level of care days billed.

FL 42 Revenue Codes

Required. Line 1-23. Enter the appropriate four-digit revenue code in FL 42 from the chart below to identify specific level of care and ancillary charges.

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 charges on the final claim page only indicated using Revenue Code 0001.

Note: Each revenue code may only be used once.

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

REVENUE CODES - FL 42

Daily Rates

COMAR DESCRIPTION	REVENUE CODE DESCRIPTION	REVENUE CODE
Resident Care Day	Rm & Brd Semi-Private - General	0120
Ventilator Resident Care Day	Respiratory – Other	0129
Therapeutic Bed Hold Day	Leave of Absence – Therapeutic Lv.	0183
Coinsurance Day	All Inclusive Rm & Brd	0101
Administrative Day (with code 75 and span in FL36)	Administrative Day	0169

Other Costs (billed in addition to Daily Rates)

COMAR DESCRIPTION	REVENUE CODE DESCRIPTION	REVENUE CODE
Class A Support Surface	Durable Medical Equipment – General	0290
Class B Support Surface	Durable Medical Equipment – Other	0299
Bariatric Bed - A	Complex Medical Equipment	0946
Bariatric Bed - B	Durable Medical Equipment – Rental	0291
Power Wheel Chair	Complex Medical Equipment	0947
Negative Pressure Wound Therapy	Medical/Surgical Supplies – General	0270

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 Service Units

Required. Enter the number of days or units of service on the line adjacent to the revenue code. There must be days or units of service for every revenue code except 0001. Sum the units for the therapy revenue codes.

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 - Lines 1-22. Line items allow up to nine numeric digits (0,000,000.00); seven 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).

FL 48 Non-Covered Charges

Not required.

FL 49 Reserved for Assignment by NUBC – NOT USED

FL 50 a-c Payer Name

Not required.

- Line 1: 50a is the Primary Payer Name.
- Line 2: 50b is the Secondary Payer Name.
- Line 3: 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-c Health Plan Identification Number

Not required.

FL 52 a-c Release of Information Certification Indicator

Not required.

FL 53 a-c Assignment of Benefits Certification Indicator

Not required.

FL 54 a-c Prior Payments - Payer

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.

DO NOT REPORT MEDICARE PRIOR PAYMENTS IN THIS FIELD.

FL 55 a-c Estimated Amount Due

Not required.

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 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 Other (Billing) Provider Identifier – Legacy

Required. A unique identification number assigned to the provider submitting the bill by the health plan. Enter the Nursing Facility's 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-c Insured's Name

Not required.

FL 59 a-c Resident Relationship to Insured

Not required.

FL 60 a-c Insured's Unique ID

Required. Enter the Medical Assistance number of the insured as it appears on the Medical Assistance card.

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 resident'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

Web EVS: Providers may verify a resident's current Medicaid eligibility by using the web-based eligibility services available for providers who are enrolled in eMedicaid. To access this service, please go to https://encrypt.emdhealthchoice.org/

FL 61 a-c Insured's Group Name

Not required.

FL 62 a-c Insured's Group Number

Not required.

FL 63 a-c Treatment Authorization Code

Not required.

FL 64 a-c Document Control Number (DCN)

FUTURE USE. The control number assigned to the original bill by the health plan or the health plan's fiscal agent as part of their internal control. Required when Type of Bill Frequency Code (FL 04) indicates this claim is a replacement or void to a previously adjudicated claim.

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: Not 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 resident for care).

Always code to the most specific level possible, but do not enter any decimal points when recording codes on the UB04.

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

NOTE: 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

Not required.

FL 68 Reserved for Assignment by NUBC – NOT USED

FL 69 Admitting Diagnosis

Not required.

FL 70 a-c Resident'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)

Not required.

FL 73 Reserved for Assignment by NUBC – NOT USED

FL 74 Principal Procedure Code and Date

Not Required

FL 74 a-e Other Procedure Codes and Dates

Not Required.

FL 75 Reserved for Assignment by NUBC – NOT USED

FL 76 Attending Provider Name and Identifiers

Not Required.

- Line 1: Not required.
- Line 2: Secondary Identifier Qualifiers: Not required.
- Line 3: Attending Physician Name: Not Required.

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. Please refer to Code List Qualifier B3 – Taxonomy Codes.

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

Notes

Code List Qualifiers:

01-A0 Reserved for National Assignment

A1 National Uniform Billing Committee Condition Codes (FL 18-28)
Right column is blank.

Example:

A	1	4	4																				

A2 National Uniform Billing Committee Occurrence Codes (FL 31-34)

Example:

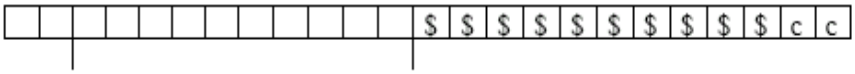
A	2	0	1														0	2	2	8	0	6

A3 National Uniform Billing Committee Occurrence Span Codes (FL 35-36)
All positions fully coded in the right column.

Example:

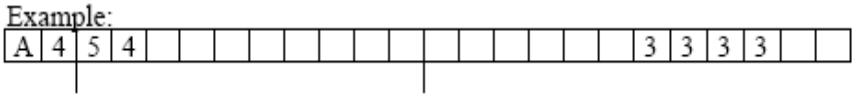
A	3	M	4								0	3	0	1	0	6	0	3	0	9	0	6

A4 National Uniform Billing Committee Value Codes (FL 39-41)
For Value Codes, there is an implied dollar/cents delimiter in the right column of FL 81 separating the last two positions as illustrated below.



See FL 39-41 for special rules for reporting values. Whole numbers or non-dollar amounts are right justified to the left of the implied dollars/cents delimiter. Do not zero fill the positions to the left of the implied delimiter. However, values are reported as cents, thus reference to the instructions for specific codes is necessary.

Example:

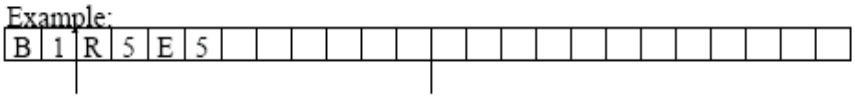


A5-B0 Reserved for Assignment by the NUBC.

B1 Standards for the Classification of Federal Data on Race and Ethnicity
Code Source: ASC X12 External Code Source 859 (Health Information and Surveillance Systems Board)

Reporting*
FOR PUBLIC HEALTH DATA REPORTING ONLY when required by state or federal law or regulations.

Example:



B3 Required. Health Care Provider Taxonomy Code.

Used for Billing Provider only. For provider types listed below, use the taxonomy code accompanying your specialty. You must submit the accompanying designated taxonomy code listed below to assure appropriate reimbursement from the Medical Assistance Program.

Specialty	Bill Type(s)	Subspecialties	Taxonomy Code
Acute General Hospital	IP: **111,** 112, 113, 114, 115, 121 OP: **131**, 135	Only the acute hospital taxonomy code should be billed on an acute hospital claim.	282N00000X
Acute Rehabilitation Hospital	IP: **111,** 112, 113, 114, 115 OP: **131**, 135	Medicaid Stand-Alone Rehab Hospital	283X00000X
Acute Rehabilitation Hospital	IP: **111,** 112, 113, 114, 115	Medicaid General Acute Hospital with Rehab	273Y00000X

Specialty	Bill Type(s)	Subspecialties	Taxonomy Code
	OP: **131**, 135	Unit	
Chronic Rehabilitation Hospital	IP: **151,** 152, 153, 154, 155		282E00000X
Chronic Hospital	IP: **151,** 152, 153, 154, 155		281P00000X
Special Other Acute Hospitals	IP: **111,** 112, 113, 114, 115 OP: **131**, 135	Pediatric Inresident	282NC2000X
Special Other Chronic Hospitals	IP: **151,** 152, 153, 154, 155	Pediatric Inresident	281PC2000X
Nursing Facility	211, 212, **213,** 214		314000000X
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											