Chap 9: Billing on the UB Claim Form

Introduction

The UB claim form is used to bill for all hospital inpatient, outpatient, emergency room services, dialysis clinic, nursing home, free-standing birthing center, residential treatment center, and hospice services for Health Choice Insurance Company (Health Choice).

- Revenue codes are used to bill line-item services 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 0651, 0652, 0655, and 0656 can only be billed on a UB with a bill type 81X-82X (Special Facility Hospice)
- ICD-10 diagnosis codes are required and must be valid on the date of admission
- Health Choice does not accept DSM-54 diagnosis codes, and behavioral health services billed with DSM-54 diagnosis codes will be denied
- ICD-10 procedure codes must be used to identify surgical procedures billed on the Inpatient UB
- CPT/HCPCS and modifiers(as appropriate) must be used in combination with Revenue codes to identify services rendered on the Outpatient UB

The pay to and practice addresses on the claim form must match the information in the Health Choice claims payment system. Your Provider Services Representative can assist with corrections if needed.

Documentation Requirements

Providers must include all required documentation with the claim submission. Failure to do so may result in denial of the claim. Health Choice reserves the right to request additional documentation of the claim.

Completing the UB Claim Form

Listed below are *required* field numbers. Each field number corresponds with the field numbers shown on the UB-04 claim form. This information should be used to supplement the information in the AHA Uniform Billing Manual for the UB form.

1. **Provider Data- Required**

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

1.	**Arizona Hospital** **123 Main Street** **Scottsdale, AZ 85252**

2. **Pay-To name and Address- Required if Applicable**

The address that the provider submitting the bill intends payment to be sent if different than that of the Billing Provider (see #1).

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. Health Choice will report this number in correspondence, including the Remittance Advice, to provide a cross-reference between the Health Choice 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 *AHA Uniform Billing 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 FROM	PERIOD THROUGH	7. COV'D
86-1234567			

6. Statement Covers Period-Required

Enter the beginning and ending dates of the billing period. This should be the date the patient was admitted for care through end of care and cannot be greater than the date indicated in box 12.

5. FED TAX NO.	6. STATEMENT COVERS FROM	PERIOD THROUGH	7. COV'D
	02/15/03	**02/20/03**	
	or		
	02/15/2003	**02/20/2003**	

7. Reserved -Not required

8. a – e. Patient Name/Identifier-Required

Last name, first name and middle initial of the patient and the patient identifier as assigned by the payer.

9. **Patient Address- Required**

The mailing address of the patient.

10. **Patient Birth Date-Required**
11. **Patient Sex-Required**
12. **Admission/Start of Care Date-Required**

The start date is required for all inpatient claims. For inpatient claims, this is the date treatment began.

13. **Admission Hour-Required if applicable**
14. **Priority (Type) of Visit (Inpatient only)-Required**

Required for all inpatient claims. 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 to do so, or as verified by the American College of Surgeons and involving trauma activation.

15. **Point of Origin for Admission or Visit (Inpatient only)-Required**
16. **Discharge Hour (Inpatient only)-Required if applicable**
17. **Patient Discharge Status (Inpatient only)-Required**

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

1. Discharged to go home or self-care (routine discharge)
2. Discharged/Transferred to a short-term general hospital for inpatient care Discharged/Transferred to Skilled Nursing Facility
3. Discharge/Transferred to a facility that provides custodial or supportive care
4. Discharge/Transferred to a designated cancer center or children's hospital
5. Discharge/Transferred to home under care of organized home health service organization in anticipation of covered skilled care
6. 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 Discharged/Transferred to a Swing Bed

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

63 Discharge/Transferred to a Long Term Care Hospital

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

28. Condition Codes- Required if applicable

A code(s) used to identify conditions or events relating to this bill that may affect processing.

29. Accident State-Required if applicable

30. Reserved -Not required

Not currently used.

31 – 34. Occurrence Codes and Dates-Required if applicable

35 – 36. Occurrence Spans Codes and Dates-Required if applicable

A code of related dates that identify an event that relates to the payment of the claim.

37. Reserved -Not required

Not currently used.

38. Responsible Party Name and Address-Required if applicable

The name and address of the party responsible for the bill.

39 – 41. Value Codes and Amounts -Required if applicable

A code structure to relate amounts or values to identify data elements necessary to process this claim as qualified by the payer organization. These fields contain codes and the dollar amounts related to them identifying data required for processing claims.

42. Revenue Codes -Required

Codes that identify specific accommodation, ancillary services or unique billing calculations or arrangements. Revenue Code categories are four digit *codes.*

42. REV.	43. DESCRIPTION	44.	46. SERV. UNITS
1			
2			
2			

43. Revenue Code Description/NDC code -Required/NDC if applicable

Enter the description of the revenue code billed in Field 42. See *Chapter 7 – General Billing Rules for* description of revenue codes.

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

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

44. HCPCS/Accommodation 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. Hospitals must enter the appropriate CPT/HCPCS code for lab, radiology, and pharmacy revenue codes. Hospitals must enter the appropriate CPT/HCPCS codes and modifiers when billing for outpatient services.

42. REV.	43. DESCRIPTION	**44.**	46. SERV. UNITS
		1,088.00	
		855.95	
		959.00	

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

42. REV.	43. DESCRIPTION	44. HCPCS/RATES	46. SERV. UNITS
0250	N400074115278 ML10	J1642	2.00

45. Service Date (Outpatient)-Required

The date (MMDDYY) the *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.

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 member has been discharged, Health Choice covers the admission date to, but not including, the discharge date. Accommodation days reported must reflect this. If the member expired or has not been discharged, Health Choice covers the admission date through last date billed.

47. Total Charges -Required

Total charges pertaining to the related revenue code for the current billing period is entered in the statement covers period. Total Charges includes both covered and non-covered charges. 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.

Note – the 23 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 on the final page. Use Rev Code 0001 for total charges.

48. Non-covered Charges-Required if applicable

Reflect the non-covered charges for the payer as it pertains to the related revenue code.

49. Reserved-Not required

Currently not used.

50. Payer Name (A-C) -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 member and from which the provider might expect some reimbursement. If there are no payers other than Health Choice Insurance Co, Health Choice will be the only entry.

51. Health Plan Identification Number (A-C)-Required

This is a number used by the health plan to identify itself.

52. Release of Information Certification Indicator (A-C)-Required

Code indicates whether the provider has on file a signed statement (from the patient or the patient's legal representative) permitting the provider to release data to another organization.

53. Assignment of Benefits Certification Indicator (A-C)-Required

Code indicates provider has a signed form authorizing the third party payer to remit payment directly to the provider.

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

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

A. Primary B. Secondary C. Tertiary

55. (A-C) Estimated Amount Due – Payer-Not required

The amount estimated by the provider to be due from the indicated payer (estimated responsibility less prior payments).

56. National Provider Identifier (NPI) – Billing Provider-Required

The unique identification number assigned to the provider submitting the bill; NPI is the National Provider Identifier.

57a. Other (Billing) Provider Identifier-Required if applicable

58. (A-C) Insured's Name -Not required

The name of the individual under whose name the insurance benefit is carried.

42. (A-C) Patient's Relationship to Insured-Not required

Code indicating the relationship of the patient to the identified insured.

43. (A-C) Insured's Unique Identifier-Not required

The unique number assigned by the health plan to the insured.

44. (A-C) Insured's Group Name-Not required

The group plan name through which the insurance is provided to the insured.

45. (A-C) Insured's Group Number -Not required

The identification number, control number, or code assigned by the carrier or administrator to identify the group number under which the individual is covered.

46. (A-C) Treatment Authorization Code-Not required

Number or other indicator that designates that the treatment indicated on this bill has been authorized by the payor. If there is a Prior Authorization approved within the Health Choice system, the claim will validate the presence of the Authorization during processing.

47. Document Control Number (DCN)-Not required

A control # assigned to the original bill.

48. (A-C) Employer Name (of the Insured)-Required

The name of the employer that provides health care coverage for the insured individual.

49. Diagnosis and Procedure Code Qualifier (ICD)-Required

The qualifier that denotes the version of International Classification of Diseases (ICD) reported.

67 A – Q. Principal and Other Diagnosis Codes and POA Indicator-Required

Enter the principal and other ICD-10 diagnosis codes. Behavioral Health Providers must NOT use DSM-5 diagnosis codes. The POA indicator applies to the diagnosis codes for claims involving inpatient admissions.

68. Reserved-Not required

69. Admitting Diagnosis -Required

Required for **inpatient** bills. Enter the ICD-10 diagnosis code that represent the significant reason for admission.

70 A-C. Patient's Reason for Visit (Outpatient only)-Not required

71. Prospective Payment System (PPS) Code-Not required

72 A – C. External Cause of Injury (ECI) Code-Required if applicable

Enter trauma diagnosis code, if applicable

73. Reserved-Not required

Currently not used.

74 A – E. Principal and Other Procedure Codes and Dates-Required if applicable

Required on INPATIENT claims when a procedure was performed. Not required on Outpatient claims. Enter the ICD-10 code that identifies the inpatient procedure performed at the claim level during the period covered by the bill and the corresponding date. Enter date as MMDDYY.

75. Reserved-Not required

76. Attending Provider Name and Identifiers (NPI)-Required if applicable

The Attending Provider is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim. Required on INPATIENT claims and to indicate the Primary Physician responsible on a Home Health Agency Plan of Treatment.

77. Operating Physician Name and Identifiers (NPI)-Required if applicable

The name and identification number of the individual with the primary responsibility for performing surgical procedures. Required if a surgical procedure code is listed on the claim.

78 – 79. Other Provider (Individual) Names and Identifier-Not required

The name and NPI number of the individual corresponding to the Provider Type category indicated in this section of the claim.

80. Remarks Field -Required if applicable

Area to capture additional information necessary to adjudicate the claim. Required when a claim is a replacement or void to a previously adjudicated claim and the Bill Type (FL-04) indicates a void or replacement.

81. Code – Code Field-Required if applicable

Used to report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by NUBC.