

Nursing Facility UB-04 Paper Claim

Claim form billing instructions for the
Department of Human Services





Overview

This step-by-step presentation is intended to provide information to assist those who bill the Department of Human Services for Medicaid services complete the UB-04 billing form correctly the first time. This presentation is to be used in conjunction with General Rules, your provider guidelines and supplemental information.

We hope you find this tutorial helpful.

~DHS~

MMIS

- The federal government requires DHS to process Medicaid claims through the automated claim processing system which is MMIS.
- This system is a combination of people and computers working together to process claims.
- This system performs daily edits for presence and validity of data.
- DHS staff only reviews claims that MMIS cannot make a payment decision based on the information submitted on the claim and other system related data (*i.e.*; eligibility).

Claims Processing

- Paper claims submitted by mail go to the DHS Office of Document Management (ODM) Imaging Unit.
- ODM processes hardcopy claims using Optical Character Recognition (OCR) scanning.
- Make sure your claim form meets OCR specifications.
- A Remittance Advice (RA) listing all claims adjudicated is mailed to the provider (with payment if appropriate).
- **NOTE:** Effective August 1, 2009, only red forms will be acceptable.

Claim processing times

- 80% of the department's claim volume is electronic.
- Electronic claims process in real-time and usually adjudicate the week in which they are submitted.
- Paper claims may take up to three weeks for processing.
- DMAP pays providers on a weekly Friday cycle.
- Electronic fund transfers are processed on Wednesdays in the week following the Friday claims cycle.
- Less than two percent of claims suspend. Once they suspend, DMAP works them within 14 days.



Prior to submitting a paper claim

- Verify eligibility to assure the client is eligible on the date of service for the services provided.
- Bill third-party resources first.
- Check the provider number to verify the claim will be submitted for the correct provider.

A few tips!

- When submitting handwritten claim forms, you must use blue or black ink, never use red ink.
- Make sure your hand writing is legible and clearly indicates zero's (0) versus O's, five's (5) versus S's, and eight's (8) versus B's.
- If possible, submit no more than twenty-two lines of services per claim form.
- Do not use liquid whiteout.
- Check your printer alignment.

Form suppliers

- The UB-04 form is not supplied by DHS.
- Forms are available by contacting one of the following:
 - Local business forms suppliers
 - Standard Register Company, Forms Division (800-755-6405)



Introducing the UB-04

1	2	3a. PAT. CNTL. #	4. TYPE OF BILL
		b. MEDI. REC. #	
		5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM THROUGH
8. PATIENT NAME	a	9. PATIENT ADDRESS	a
10. BIRTHDATE	11. SEX	12. DATE	13. ADMISSION UP TO 14. TYPE 15. SRC 16. DHR 17. STAT
			18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. ACDT STATE 30.
31. OCCURRENCE DATE	32. OCCURRENCE DATE	33. OCCURRENCE DATE	34. OCCURRENCE DATE
35. CODE	OCCURRENCE SPAN FROM THROUGH	36. CODE	OCCURRENCE SPAN FROM THROUGH
37.			
38.	39. CODE	VALUE CODES AMOUNT	40. CODE
	a		VALUE CODES AMOUNT
	b		41. CODE
	c		VALUE CODES AMOUNT
	d		
42. REV. CD.	43. DESCRIPTION	44. HCPCS / RATE / HIPPS CODE	45. SERV. DATE
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
50			
51			
52			
53			
54			
55			
56			
57			
58			
59			
60			
61			
62			
63			
64			
65			
66			
67			
68			
69			
70			
71			
72			
73			
74			
75			
76			
77			
78			
79			
80			
81			
82			
83			
84			
85			
86			
87			
88			
89			
90			
91			
92			
93			
94			
95			
96			
97			
98			
99			
100			



The UB-04 claim form

- Not sure if you are using the correct form?
- The bottom left corner will say UB-04 CMS-1450.

Box 1 - optional

1	Nursing Facility			
	PO Box ###			
	Anytown, OR 97###			

Billing Provider Information

- Enter the name and address of the Nursing Facility that is requesting to be paid for the services rendered.

Box 3a - optional

3a PAT. CNTL #	X123400
-------------------	----------------

Patient Account Number

- Enter your resident's account number here.
- This box allows up to twelve characters.
- This number will appear on your Remittance Advice (RA).

Box 4 - required

4 TYPE
OF BILL

651

Type of Bill

Enter the three-digit numeric code to identify the type of facility, type of care provided, and frequency of services you are billing for.

ICF	SNF	Swing	Description
651	211	181	Admit through discharge.
652	212	182	First claim.
653	213	183	Continuing claim.
654	214	184	Last claim.

Note: SNF type of bill is not used at this time, but will be at a later date.

Box 6 - required

6	STATEMENT COVERS PERIOD FROM	THROUGH
	120108	123108

Statement Covers Period

- Enter the beginning and ending dates of services covered by this claim.
- “From” date is the date services began.
- “Through” date is the last paid date for the service period.

Statement covers period - notes

- If billing for an entire month and there is no break in service or change in level of care, the through date will be the last day of the month.
- When a resident is discharged, the through date must be one day prior to the day of discharge.
 - Example: Admitted 12/01/08
Discharged 12/15/08
Through date will be 12/14/08 (it will read 12/01/08 thru 12/14/08).
- **NOTE:** Submit a new UB-04 each time there is a break in service.

Box 7-required for SNF claims only

7 XOVR

Crossover Indicator

NOTE: This field is not used at this time, but will be required at a later date.

- Enter “XOVR” to indicate the claim is a Medicare or a Medicare Managed Care crossover claim.
- Leave this blank for ICF claims.

Box 8b - required

8 PATIENT NAME	a	
b	Resident, Your	

Patient Name

- Enter the resident's name exactly as it is printed on the Medical Care Identification.
- Use the client's last name first.
- Do not use nicknames.

Box 12 - required

12	DATE
	120108

Admission Date

- Enter the actual date of admission.

Box 13 - required

13 HR
10

Admission Hour

- Enter the hour of admission in military time.

- Example:

01	1:00 a.m.
10	10:00 a.m.
14	2:00 p.m.
23	11:00 p.m.

Box 16 - optional

16 DHR
15

Discharge Hour

- Required if the resident discharged on the last day of the “Statement Covers Period”.
- Enter the discharge hour in military time.
- Example:

01	1:00 a.m.
10	10:00 a.m.

Box 17 - required

17 STAT
30

Discharge Status

- Enter resident discharge status.
- Enter 30 on nursing facility claims.

NOTE: The last day in the statement covers period will not be paid if using any other code.

Box 31 - optional

31	OCCURRENCE
CODE	DATE

Occurrence

- Enter the two-digit code to indicate the type of occurrence and the date of the occurrence:
 - 01 Auto accident
 - 04 Employment related accident
- Pursue all prior resources first.
- DHS is the payer of last resort.

Box 35 - required for SNF claims only

35 CODE	OCCURRENCE SPAN	
	FROM	THROUGH
70	112808	010209

NOTE: This field is not used at this time, but will be required at a later date.

- **Occurrence Span:**

- Enter 70 occurrence code.
- Enter the date the resident was admitted to the hospital
- Enter the date the resident discharged from the hospital.
- To receive coinsurance payment, or the 20-day post hospital extended care (PHEC) benefit, this box must be completed.

Box 39 & 40 - required for SNF claims only

	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT
a	A1	695 00	A2	95 00
b				
c				
d				

Value Codes

NOTE: This field is not used at this time, but will be required at a later date.

- Box 39:
 - Enter value code “A1” to identify Medicare Part A or Part B deductible, and the amount.
- Box 40:
 - Enter value code “A2” to identify Medicare Part A or Part B coinsurance, and the amount.

Middle section

42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
							1
							2
							3
							4
							5
							6
							7
							8
							9
							10
							11
							12
							13
							14
							15
							16
							17
							18
							19
							20
							21
							22
PAGE ____ OF ____		CREATION DATE	TOTALS →				23

Red = Required

Box 42 - required

42 REV. CD.	
1	
2	100
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	001
24	

Revenue Center Codes

- Enter a three-digit revenue center code which most accurately describes the service provided.
- Enter 001 in line 23 to indicate claim total charges.

Revenue center codes

Type of care	Revenue code	Level of care	Description
ICF/LTC	100	01	Basic
ICF/LTC	100	02	Pediatric
ICF/LTC	100	03	Complex medical add-on
ICF/LTC	100	04	Enhanced care
ICF/LTC	100	05	Outlier
ICF/LTC	100	06	Out-of-state NF
Swing bed	101	N/A	Hospital swing bed (short stay)
20 day PHEC	101	N/A	Post hospital extended care
SNF	022	N/A	Medicare (no coinsurance days)
SNF	022	N/A	Medicare (with coinsurance days)

Note: Revenue center codes 101 and 022 are not used at this time, but will be at a later date.

Box 44 - do not use

44 HCPCS / RATE / HIPPS CODE

Leave blank

- **Leave this box blank.**
- If anything is entered here, the claim will deny, suspend, or pay at an incorrect amount.

Total - required

TOTALS 	4,200 00
---	-----------------

Total Charges

- Enter the total amount billed.
- Add the charges as indicated from column 47.
- Do not list credits.
- Do not use dashes.
- Each claim form is a separate document, and is to be totaled as such.

Bottom section

50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	53 ASS SEN	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										68	
69 ADMIT DX	70 PATIENT REASON DX		a	b	c	d	71 PPS CODE	72 ECI	a	b	c	73
74	PRINCIPAL PROCEDURE CODE DATE		b.	OTHER PROCEDURE CODE DATE		b.	OTHER PROCEDURE CODE DATE		75	76 ATTENDING NPI		QUAL
										LAST		FIRST
a.	OTHER PROCEDURE CODE DATE		d.	OTHER PROCEDURE CODE DATE		a.	OTHER PROCEDURE CODE DATE			77 OPERATING NPI		QUAL
										LAST		FIRST
0 REMARKS			31CC	a					78 OTHER NPI		QUAL	
				b					LAST		FIRST	
				c					79 OTHER NPI		QUAL	
				d					LAST		FIRST	

Red = Required

Yellow = Optional

Box 50 - optional

50 PAYER NAME	
A	Primary payer
B	Secondary payer
C	Tertiary payer

Payer Name

- Enter the names of up to three payer organizations in order.

Example:

If Medicare is primary, enter on line A.

If another Third Party payer is secondary, enter on line B.

If Medicaid is tertiary payer, enter on line C.

Box 54 - optional

54 PRIOR PAYMENTS	
	:
	:
	:
	:

Prior Payments

- Enter the total amount paid by other third party resource's.
- Do not list write-off's.
- Do not include how much DHS previously paid.
- Do not include copayments.
- Use this box if a resident has long-term care insurance.

Box 56 - required

56 NPI	#####
--------	-------

National Provider Identifier (NPI)

- Enter your ten-digit NPI.

Box 57 - required

57	
OTHER	#####
PRV ID	

Provider Number

- Enter your six or nine-digit (DHS issued) provider number.
- Do not list other payer provider numbers.
- Correspond the placement number as outlined in box 50 instructions.

Box 60 - required

60 INSURED'S UNIQUE ID
XX###X#X

Insured's Unique ID

- Enter the resident's eight-character prime identification number (clearly enter letters versus numbers).
- Enter the number exactly as it appears on the Medical Care Identification.
- Correspond the placement as outlined in box 50 instructions.

Box 66 - required

66 DX	2989	67	
----------	------	----	--

Diagnosis Code

- Enter the primary diagnosis code of the resident by using a valid ICD-9-CM code carried out to its highest degree of specificity.
- The diagnosis code must be the reason chiefly responsible for the service being provided.
- You may enter up to five codes if necessary listing them in boxes 67 - 67D.
- Do not use the decimal point.

Box 69 - required

69 ADMIT DX	2989
----------------	-------------

Admit DX

- Enter the admitting diagnosis of the resident by using a valid ICD-9-CM code carried out to its highest degree of specificity.
- Do not use the decimal point.

Box 78 - optional

78 OTHER		NPI #####	QUAL		#####
----------	--	-----------	------	--	-------

Other Physician ID

- This box is only required when the resident has a Primary Care Manager (PCM).
- Enter the ten-digit NPI of the PCM.
- Enter the six or nine-digit (DHS issued) provider number of the PCM.

Box 80 - optional

80 REMARKS
NC

Third Party Resource

- If the resident has other medical coverage, enter the appropriate two-digit third party resource (TPR) explanation code.
- A code must be listed when the other insurance did not make a payment, and always when the recipient has more than one other insurance carrier.

Single carrier TPR codes

UD	Service under deductible
NC	Service not covered by insurance policy
PN	Patient not covered by insurance policy
IC	Insurance coverage canceled/terminated
IL	Insurance lapsed or not in effect on date of service
IP	Insurance payment went to policyholder
PP	Insurance payment went to patient
NA	Service not authorized or prior authorized by insurance
NE	Service not considered emergency by insurance
NP	Service not provided by primary care provider/facility

Single carrier TPR codes continued on next slide

Single carrier TPR codes

MB	Maximum benefits used for diagnosis/condition
RI	Requested information not received by insurance from patient
RP	Requested information not received by insurance from policyholder
MV	Motor Vehicle Accident Fund (MVAFF) maximum benefits exhausted
AP	Insurance mandated under administrative/court order through an absent parent and not paid within 30 days
OT	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurance)

Multiple carrier TPR codes

MP	Primary insurance paid – secondary paid
SU	Primary insurance paid – secondary under deductible
MU	Primary and secondary under deductible
PU	Primary insurance under deductible – secondary paid
SS	Primary insurance paid – secondary service not covered
SC	Primary insurance paid – secondary patient not covered
ST	Primary insurance paid – secondary canceled/terminated
SL	Primary insurance paid – secondary lapsed or not in effect
SP	Primary insurance paid – secondary payment went to patient

Multiple carrier TPR codes continued on next two slides

Multiple carrier TPR codes

SH	Primary insurance paid – secondary payment went to policyholder
SA	Primary insurance paid – secondary denied – service not authorized
SE	Primary insurance paid – secondary denied – service not considered emergency
SF	Primary insurance paid – secondary denied – service not provided by primary care provider/facility
SM	Primary insurance paid – secondary denied – maximum benefits used for diagnosis/condition
SI	Primary insurance paid – secondary denied – requested information not received from policyholder

Multiple carrier TPR codes continued on next slide

Multiple carrier TPR codes

SR	Primary insurance paid – secondary denied – requested information not received from patient
MC	Service not covered by primary or secondary insurance
MO	Other (if above codes do not apply, include detailed explanation of why there was no payment from insurances)

C
O
M
P
L
E
T
E
D

1 Nursing Facility PO Box ### Anytown, OR 97###		2		3a PAT CNTL # X123400		4 TYPE OF BILL 651	
b. MED. REC. #		5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM 120108		7 THROUGH 120108	
8 PATIENT NAME a Resident, Your				9 PATIENT ADDRESS b			
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION	
14 TYPE		15 SRC		16 DHR		17 STAT	
18		19		20		21	
22		23		24		25	
26		27		28		29 ACDT STATE	
30		31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE	
34 OCCURRENCE DATE		35 OCCURRENCE DATE		36 OCCURRENCE DATE		37	
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES 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	
1 100						31	
2						4,200 00	
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70							
71							
72							
73							
74							
75							
76							
77							
78							
79							
80							
81							
82							
83							
84							
85							
86							
87							
88							
89							
90							
91							
92							
93							
94							
95							
96							
97							
98							
99							
00							
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70							
71							
72							
73							
74							
75							
76							
77							
78							
79							
80							
81							
82							
83							
84							
85							
86							
87							
88							
89							
90							
91							
92							
93							
94							
95							
96							
97							
98							
99							
00							
01							
02							
03							
04							
05							
06							
07							
08							
09							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44							
45							
46							
47							
48							
49							
50							
51							
52							
53							
54							
55							
56							
57							
58							
59							
60							
61							
62							
63							
64							
65							
66							
67							
68							
69							
70							
71							
72							
73							

Billing Cycles

- Monthly
 - Bill on a monthly basis for resident's that are identified as still a patient (Patient status code 30, as identified in box 17).
 - Claims must be submitted on or after the 1st day of the month following the month in which services have been provided.
- Partial
 - Bill for a partial month if the resident is discharged or if the resident expires before the end of the month.
- Paid
 - Can adjust if necessary.
- Denied
 - Rebill at any time.
- Suspended
 - Wait for DHS to complete the review.

Break in service

- Any time a resident is out of the facility past midnight and is expected to return, it is considered a break in service.
- Each time there is a break in service, you must submit a separate UB-04 claim form.
 - 12/01/08 resident is admitted to a basic level of care (separate UB-04).
 - 12/05/08 resident goes to hospital and is expected to return.
 - 12/06/08 resident returns from hospital at the basic level of care and remains at the facility through the end of the month (separate UB-04).
- Notify the local SPD office so the resident's Plan of Care can be updated.

Things to remember

- Do not enter resident's liability on the UB-04.
 - Liability is automatically deducted from your total billed amount.
- Do not include the resident's level of care on the UB-04.
 - SPD enters the maximum daily amounts in MMIS.
 - Contact your local SPD office for questions concerning level of care.

SNF crossovers (XOVR)

- **NOTE:** This field is not used at this time, but will be required at a later date.
- Before billing DHS for coinsurance, you must bill the primary payer responsible for Medicare Part A benefit.
- DHS will pay coinsurance for days 21 through 100.
- Don't forget required boxes on the UB-04:
 - Box 7 enter XOVR.
 - Box 35 enter occurrence span of the date the resident was admitted to the hospital, and the date the resident discharged from the hospital.
 - Box 39 enter the appropriate value code and amount of coinsurance.
 - Box 54 enter the amount Medicare paid.

Need help?

- For assistance reading RA's or to request a re-print, contact:
 - DMAP Provider Services
 - 800-336-6016
 - dmap.providerservices@state.or.us
 - Team.Provider-ACCESS@state.or.us
- For questions specific to Long Term Care Facilities, contact:
 - Vivien VanHatten at 503-945-6528, or
 - Rose Laurente at 503-945-5779, or
 - David Allm at 503-945-6407 (program and policy)
- To view claim status on the Web:
 - Provider Web Portal <https://www.or-medicaid.gov>



Thank you!